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Chapter 1 : Maternal anxiety disorders in the postnatal period

The objective of this review was to assess the effect of professional and/or social support interventions for the treatment of postpartum depression. Search strategy We searched the Cochrane Pregnancy and Childbirth Group trials register.

Many women desire to try treatment options other than medication. Results from nine trials involving women found that both psychosocial e. The long-term benefits are unknown. Larger trials evaluating psychosocial and psychological treatments for postpartum depression are needed to provide clear conclusions about specific intervention benefits. Although the methodological quality of the majority of trials was, in general, not strong, the meta-analysis results suggest that psychosocial and psychological interventions are an effective treatment option for women suffering from postpartum depression. The long-term effectiveness remains unclear. Read the full abstract Postpartum depression is a major health issue for many women from diverse cultures. While pharmacological interventions are an effective treatment for depression, mothers are often reluctant to take antidepressant medication due to concerns about breast milk transmission or potential side-effects. It is important that non-pharmacologic interventions be evaluated for use with postpartum women experiencing depressive symptomatology. All published, unpublished, and ongoing randomised controlled trials and quasi-randomised trials of psychosocial or psychological interventions where the primary or secondary aim was a reduction in depressive symptomatology. Data collection and analysis: Both review authors participated in the evaluation of methodological quality and data extraction. Additional information was sought from several trial researchers. Results are presented using relative risk for categorical data and weighted mean difference for continuous data. Ten trials met the inclusion criteria, of which nine trials reported outcomes for women. Any psychosocial or psychological intervention , compared to usual postpartum care, was associated with a reduction in the likelihood of continued depression, however measured, at the final assessment within the first year postpartum. Both psychosocial and psychological interventions were effective in reducing depressive symptomatology. Trials selecting participants based on a clinical diagnosis of depression were just as effective in decreasing depressive symptomatology as those that enrolled women who met inclusion criteria based on self-reported depressive symptomatology. You may also be interested in:

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Chapter 2 : Project MUSE - Postpartum Depression: A Review

Treatment of postpartum depression with support was associated with a reduction in depression at 25 weeks after giving birth (odds ratio , 95% confidence intervals to). REVIEWERS' CONCLUSIONS: There is some indication that professional and/or social support may help in the treatment of postpartum depression.

Editor who approved publication: Postnatal depression PND has negative effects on maternal well-being as well as implications for the motherâ€"infant relationship, subsequent infant development, and family functioning. Given the possible intergenerational transmission of risk to the infant, the motherâ€"infant relationship is a focus for treatment and research. However, few studies have assessed the effect of treatment on the motherâ€"infant relationship and child developmental outcomes. Nineteen studies were selected for review, and their methodological quality was evaluated, where possible, effect sizes across maternal mood, quality of dyadic relationship, and child developmental outcomes were calculated. Finally, clinical implications in the treatment of PND are highlighted and recommendations made for further research. A recent review identified a number of postnatal factors placing women at increased risk to continued depressive symptoms, including younger maternal age, poor education attainment, historical episodes of depression, antidepressant use during pregnancy, child developmental problems, low parental self-efficacy, poor relationship, and the occurrence of stressful life events. The model by Milgrom et al 1 details vulnerability factors, precipitating factors including those factors which may trigger PND onset: The model also explains that sociocultural factors may play a role in exacerbating and maintaining PND and they account for heterogeneity in vulnerability to experiencing PND across women. An episode of PND generally lasts from 2 months to 6 months in duration and as long as 1 year in some cases. Notwithstanding, there are further cost implications in terms of child and adolescent services accessed due to the increased risk associated with having a parent with PND. Treatment is, therefore, a major public health concern and the one which spans both maternal and infant mental health. Following an episode of PND, women are predisposed to future risk of depressive episodes with subsequent children. Crucially, the first year is an important period for infants to develop self-regulatory skills. Interventions focusing exclusively on maternal depression may not be sufficient alone to buffer against the risks to infant development. Conceptualizing the depressive episode within the context of the perinatal period may promote adaptive developmental pathways in the infant. It is therefore necessary to measure outcomes in order to understand if interventions for PND exert a protective effect on the motherâ€"infant relationship and infant development in addition to maternal mood. Intergenerational transmission of risk to children of women with PND Goodman and Gotlib 37 highlighted the need for a developmental model, which explains the transmission and manifestation of vulnerability in infants. The nature of the association between PND and infant development is especially complicated by limited understanding of the full impact and risk of maternal mood and cognitions on infant developmental pathways. In their integrated model, Goodman and Gotlib 37 detail how the effects of PND are implicated across the intergenerational gap. Effect of PND on infant development Evidence suggests that PND in the parent may contribute to serious effects on infant cognitive and emotional development and is associated with later psychopathology and atypical development. However, effects varied with characteristics of children involved, including sex and contextual factors as indicated by the aforementioned model. They also suggested that timing and course of PND were more pervasive in their effects on child development. Research using the face-to-face video interaction paradigm has demonstrated that mothers with PND are more negative and their infants less positive than nondepressed motherâ€"infant dyads. They also found that full IQ scores were lower in children of mothers with PND, demonstrating the lasting effects of PND occurring early in the postpartum period. Recent systematic reviews by Kingston et al 45 and Kingston and Tough 46 evaluated longitudinal research of the effects of maternal distress, including postnatal distress, on infants and school-aged children. They reported particular effects of postnatal maternal distress on both infant 45 and school-aged child 46

cognitive and socio-emotional development. They also summarized small-to-moderate effects of postnatal maternal distress on the behavior of school-aged children. The infantâ€"caregiver relationship has been widely recognized to play an important role in child development. Research by Stein et al 48 demonstrated that disturbances in maternal cognitions of women with PND may play a causal role in the negative effects on the motherâ€"infant relationship. Gerhardt 50 reviewed evidence that prolonged levels of cortisol in early infancy have consequences for neural systems implicated in how infants tolerate stress later in life, namely the prefrontal cortex and Hypothalamic-pituitary-adrenal axis. Emerging imaging research completed with adult children of women with PND captured a significant association between their attachment security at 18 months and neural responding at 22 years of age. Further research identified that compared with controls, women with PND are less able to identify happy faces potentially leading to decreased responsiveness toward their infants. This secure attachment, which develops between the mother and infant, also illustrates that the care the infant receives can impact in a protective manner on the developing child. Within the available literature, several approaches have been identified and have demonstrated variable levels of efficacy, including various antidepressant treatments, 55 , 56 antenatal group interventions, 57 psychoeducation, 58 , 59 cognitive behavior therapy CBT , 60 , 61 interpersonal psychotherapy IPT , 34 , 62 , 63 and interventions focusing on the motherâ€"infant relationship 64 â€" 66 and baby massage. The majority of reviews on the subject have explored efficacy in relation to maternal mood. Furthermore, there is emerging evidence that the treatment of PND alone is not sufficient to improve the motherâ€"infant relationship as well as child development. They do not reflect mechanisms or moderators proposed by Goodman and Gotlib. While there is an extensive literature of evaluation studies on various interventions for PND, little is known about the benefit of interventions to the quality of the motherâ€"infant relationship and moreover, child developmental outcomes. Poobalan et al 74 addressed this issue through an earlier review of treatments for PND, which focused on the motherâ€"infant dyad relationship. Outcomes were discussed in terms of child outcomes. They noted some support for dyadic-focused interventions in improving child outcomes; however, the evidence was equivocal. In contrast, the present review extends the review by Poobalan et al 74 by reporting on effect sizes, updating the search period from to , inclusion of other therapies antidepressant medication , and rigorous quality assessment, using the Clinical Tool for Assessment of Methodology CTAM 75 categories including allocation, assessment, control groups, analysis, and treatment. Most importantly, the present review considers the impact of treatments on maternal depression symptoms in addition to child outcomes. Method Search strategy The literature search included publications from to , since an earlier review by Poobalan et al 74 reviewed studies from the s to , using a standard assessment adapted from the Cochrane Collaboration and Jadad Scale. Additional searches were run using the aforementioned databases and PubMed for the dates between and Boolean searches on MeSH were conducted using combinations of the following and related terms: All titles and abstracts were initially scanned for relevance. Both single-group and randomized controlled trial RCT designs were considered for inclusion. A further inclusion criterion was that participants were experiencing low mood as indicated by a screening tool ie, Edinburgh Postnatal Depression Scale [EPDS] or a professional diagnosis of depression. Evaluation of quality of trial methodology The CTAM, an assessment tool used to evaluate the quality of psychotherapeutic trials, 75 was used in the present study because of its comprehensiveness in covering the six main areas of trial design, including sample size and recruitment method, allocation to treatment, assessment of outcomes, control groups, description of interventions, and analysis of data. There are a total of 15 items. Scores range from 0 to ; scores over 65 are regarded as good quality. Effect sizes indicate the magnitude of difference between two groups. In this review, they were also calculated separately for maternal mood, quality of dyadic relationship, and child developmental outcomes. As suggested by Cohen, 77 effect sizes were calculated individually given the heterogeneity of outcome measures and interventions. Effect sizes have only been calculated in studies where means and standard deviations were reported. Effect sizes have not been calculated in previous reviews of this literature. Results The initial search returned articles. A further articles were excluded after more detailed examination of the title and abstract.

Twenty-eight articles were removed for being duplicates or triplicates leaving 19 studies to be evaluated Figure 1 for a schematic diagram of the literature search. Only three studies 34 , 61 , 64 assessed both the quality of the dyad relationship and child outcomes. Although there was a high degree of heterogeneity across studies and measures used for assessment, effect sizes for different outcomes maternal mood, motherâ€"infant relationship, child developmental outcomes were calculated where possible. Location and sample From the 19 studies included in the review, nine were carried out in the USA, five in the UK, two in the Netherlands, two in Australia, and one in Canada. Participant characteristics Of the 19 studies, ten were carried out with a multiparous sample and three with a primiparous sample, and six of the studies did not report parity. There was high variability across study client inclusion criteria regarding how depressive diagnosis was determined. Thirteen studies included participants with a professional diagnosis of PND, and six studies included participants with probable diagnosis through public health screening. There were also differences across characteristics of participants in terms of severity of depression, marital status, and age of baby Table 1. Table 1 Participant characteristics including marital status, age of baby and mother, and level of depression at baseline across all studies Notes: Treatment type, session length, and total duration The types of interventions evaluated in this review varied greatly with respect to their focus. For example, some interventions focused on the dyadic interaction, whereas others focused on maternal depression. Clark et al 65 , 78 evaluated motherâ€"infant therapy group M-ITG , a relationship-focused intervention grounded in interpersonal, psychodynamic, and family system approaches. The M-ITG intervention focuses on a providing therapeutic intervention and peer support, b addressing infant emotional regulation and social engagement, and c promoting sensitive interaction in the dyad. Forman et al 34 and Mulcahy et al 62 also examined IPT and described it as focusing on social role transitions ie, transition to parenthood as well as loss and grief in addition to focusing on individual interpersonal aspects. Kersten-Alvarez et al 81 also evaluated a motherâ€"infant intervention focusing on enhancing quality of dyadic interaction, through improving maternal sensitivity using video feedback and where needed, using modeling behavior, cognitive restructuring, support, and baby massage. Jung et al 66 investigated the efficacy of a further dyadic-focused intervention. Keys to Caregiving, aims to facilitate sensitive responding to infant behaviors through enhancing understanding of the meaning of different infant behaviors. The intervention involved practice with the infant during the session and at home. Keys to caregiving Capital sessions included understanding of infant states, infant behaviors, infant cues, modulation, and feeding. In their RCT, Cooper et al 82 compared routine care health visiting with no additional input with CBT, nondirective counseling, and psychodynamic therapy. Within the CBT sessions, a woman was also encouraged to problem solve in a systematic way, and examine patterns of thinking about her infant and herself as mother. Two antidepressant medications nortriptyline and sertraline were also evaluated. Mode of delivery included both individual and group delivery as well as mixed individual and group. A summary of type of treatment, session length, and treatment duration, CTAM scores, and domains of assessment maternal affect, dyad relationship, and child development across all studies is presented in Table 2. Table 2 Characteristics of studies assessing interventions for PND which include either dyad or child developmental outcomes Notes: Overall, most studies eleven of the 19 studies included in the review had a CTAM score below 65, which is described as inadequate by the authors of the CTAM. Nine of the 19 studies had a sample size greater than 27 in each treatment group. Small sample sizes are a long-standing limitation within the PND literature. A large proportion of studies with PND populations failed to recruit to target, and as such they were underpowered. This is a difficulty experienced across trials. Allocation While most studies described whether there was true random allocation or minimization allocation across treatment groups, only ten studies described the process of randomization. All but three studies 66 , 68 , 86 had assessors who were independent of treatment delivery ie, they were not the therapist on the trial. Eight studies reported that assessments were carried out blind to treatment group allocation. Control groups While most studies utilized a RCT design, three studies 34 , 67 , 83 reported using both, no treatment or waitlist control WLC group and a control group that controlled for nonspecific effects ie, nondepressed comparison group. Analysis All studies

conducted appropriate analyses given their design and sample sizes. Active treatment All interventions employed were psychotherapy or psychosocial interventions with the exception of one study, 55 which was an evaluation of two types of antidepressant medications. Nine of the studies provided an adequate description of the treatment, reported the use of a protocol or manual, as well as an assessment of adherence to the protocol. In their evaluation of the efficacy of a behavioral intervention delivered by advanced practice nurses and research assistants, which involved coaching designed to promote maternal responsiveness, Horowitz et al 80 reported that women who had received the behavioral coaching showed a significantly higher level of responsiveness posttreatment. Smaller effect sizes Table 3 were calculated across several other studies.

Chapter 3 : Group treatment for postpartum depression: a systematic review

RESEARCH. The present paper is a systematic, integrative review that includes several studies with different methodologies to answer questions about the relationship between genetic factors and the development of postpartum depression.

Annette Eneberi For many years, the presence of depression in the postnatal period has formed the basis of much research into postpartum mental health difficulties. However, as understanding and recognition of perinatal mental health has grown, so has the range of disorders studied. In more recent years, increasing attention has been drawn to the presence of anxiety disorders during this time-period. So what has the research to-date told us about these difficulties in the postnatal period? A recent comprehensive review Goodman et al. The authors aimed to evaluate the current knowledge-base on diagnosable anxiety disorders in mothers within the first year after childbirth. A meta-analytical approach was used to explore prevalence of each anxiety disorder during this time-period, with additional descriptions provided about key related factors, such as timing of onset, the course of symptoms, possible risk factors, maternal or infant outcomes, and current evidence regarding treatment of these difficulties. A key criteria for inclusion in the review was that studies included a diagnostic interview to classify participants as having a diagnosable anxiety disorder. Diagnostic status was widened up to include studies looking at anxiety disorders diagnosed prior to childbirth if women were followed up into the postnatal period. It is also important to note that some individual studies modified diagnostic criteria, thus there may be some variation in this between studies. The authors tried to account for publication bias the possibility that positive findings in small studies may have impacted on the results using statistical adjustments of the data. Results Prevalence The meta-analysis revealed that 8. Looking at each specific anxiety disorder, the meta-analysis revealed the following prevalence rates range in brackets: The studies revealed a varying course of symptoms throughout the postpartum, from study to study. For panic disorder, interpersonal abuse in the last year appeared to be a risk factor, whereas lactation appeared to delay onset of symptoms. For OCD, a history of depression, maternal age and delivery by caesarean section were some of the found risk factors. None were reported for GAD or phobias in this time-period. Impact on mothers and their infants Knowledge seems limited into the possible impact of maternal anxiety on parenting, maternal functioning, and child outcomes. Those studies which explored this suggested a possible deleterious impact, such as: Treatment Very few studies were found looking at treatment. One explored the use of cognitive behavioural therapy CBT for OCD and one at the use of CBT for improving anxiety in general not specific to one type of anxiety disorder. Both indicated that CBT may be an effective treatment, but more research is clearly needed before any conclusions can be drawn. Strengths and limitations The authors provide a comprehensive critical review of the literature and the evidence to-date about diagnosable anxiety disorders in postpartum women. The review provides helpful information relating to the prevalence, onset, course, correlates and risk factors, outcomes and treatment of postnatal anxiety disorders. The review also highlights the gaps in the literature and emphasises the need for further research and clinical developments. The review used a clear systematic search strategy to extract papers and answer specific research questions for each disorder, but they only searched 3 databases Medline, PsycINFO and CINAHL and so may have missed research only indexed elsewhere e. However, readers must interpret the findings with caution. Some of the studies were based on extremely small sample sizes. In addition, there were limited studies available which investigated prevalence, and of those that did large variability was reported. This variation shows how hard it is to draw conclusions from just one study, and the importance of looking at all the evidence together. However, we also need to look at the specific populations included in each of these studies e. For example, in the majority of studies women were recruited from anxiety disorder clinics and subsequently may represent women with increased disorder severity. It is possible that the meta-analytical results may therefore over-estimate the prevalence in the general postnatal population. However, the authors propose that the

methodology of the individual studies may actually mean their meta-analytical rates under-estimate postpartum prevalence. What the prevalence figures fail to tell us is how these rates compare to prevalence in the general population. The authors mention one study included in the review Vesga-Lopez et al. The only exception was social phobia, where rates were actually lower in postpartum women than in non-postpartum women. This is an important consideration: Or are these symptoms part of a picture of anxiety across a life-span, and therefore intervention needs to be broader than targeting this specific population? The review reports on few treatment studies 2 out of the 58 studies however the reason for this remains unclear. Did the exclusion criteria limit the inclusion of treatment studies, or are there limited studies on the treatment of postpartum anxiety disorders? Large variation was seen across the studies reporting the prevalence of anxiety disorders in postpartum women. Conclusions and comment The paper provides a thorough review and meta-analysis of current research evidence on anxiety disorders and their prevalence amongst postpartum women. The paper represents a clear and concise critical review of the available literature and highlights the need for further research and clinical advancements in this field. However, although a strength of the review was the strict inclusion criteria applied by the authors, this also likely limited the studies available. The review focuses on studies exploring postpartum anxiety disorders as identified through the use of clinical interviews. Whilst this represents the use of a gold standard instrument and thus a strength of the review , it may not reflect entry into mainstream clinical services, and the true picture of anxiety difficulties experienced in the postnatal period. There may be an element of anxiety that is considered to be adaptive, in terms of staying vigilant and caring for an infant. By only including studies that use a diagnostic interview to classify anxiety disorders, the results may represent experiences of those women experiencing anxiety above and beyond any level of anxiety that may be expected during this transition period. This suggests that more attention should be paid to the possible impact of maternal anxiety disorders on parenting and child outcomes, so that further thought can be given to screening, intervention and treatment for mothers and families during this time-period. More attention should be paid to the possible impact of maternal anxiety disorders on parenting and child outcomes.

Chapter 4 : Caregiver support for postpartum depression

Treatment of postpartum depression with support was associated with a reduction in depression at 25 weeks after giving birth (odds ratio , 95% confidence intervals to).

References When screening is positive for possible depression, the diagnosis should be confirmed using DSM-5 criteria, which are presented in Table 6. A major depressive episode must not be better explained by schizoaffective disorder, schizophrenia, or schizophreniform disorder. Bipolar disorder must also be excluded, especially if the patient has ever had a manic or hypomanic episode. Physicians should familiarize themselves with basic screening tools for bipolar disorder. Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1 depressed mood or 2 loss of interest or pleasure. Do not include symptoms that are clearly attributable to another medical condition. Depressed mood most of the day, nearly every day, as indicated by either subjective report e. In children and adolescents, can be irritable mood. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation. Significant weight loss when not dieting or weight gain e. In children, consider failure to make expected weight gain. Insomnia or hypersomnia nearly every day. Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down. Fatigue or loss of energy nearly every day. Feelings of worthlessness or excessive or inappropriate guilt which may be delusional nearly every day not merely self-reproach or guilt about being sick. Diminished ability to think or concentrate, or indecisiveness, nearly every day either by subjective account or as observed by others. Recurrent thoughts of death not just fear of dying , recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The episode is not attributable to the physiological effects of a substance or to another medical condition. Criteria Aâ€”C represent a major depressive episode. Responses to a significant loss e. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders. There has never been a manic episode or a hypomanic episode. This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition. Reprinted with permission from the American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th ed. American Psychiatric Association; It is reasonable to obtain basic laboratory testing when confirming the diagnosis of depression, especially in older patients, to exclude medical conditions that may mimic depression. Thyroid-stimulating hormone testing may be considered because hypo- or hyperthyroidism may cause fatigue or psychomotor changes, or weight and appetite changes. A complete blood count may be considered to evaluate for chronic infections or malignancy. Patients with anemia may present with fatigue, depression, anorexia, and weight loss. Pernicious anemia may manifest as mood changes and insomnia, warranting vitamin B12 testing. Serum electrolytes and liver function are useful tests in adults because abnormalities such as a sodium imbalance may lead to confusion, weakness, and early delirium, which may mimic depression. Hepatic encepha lopathy may also mimic depression and go unrecognized. Finally, when considering pharmacologic therapy in older patients, it is useful to know about any underlying liver impairment, which could limit the use of some medications. This article updates previous articles on this topic by Sharp and Lipsky , 47 and Maurer. A PubMed search was completed in Clinical Queries using the key terms depression and screening. The search included meta-analyses, randomized controlled trials, and reviews.

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June 25, , and July 15, The opinions and assertions contained herein are the private views of the authors and are not to be construed as official or as reflecting the views of the U. Army Medical Department or the U. Read the full article. Get immediate access, anytime, anywhere. Choose a single article, issue, or full-access subscription. Earn up to 6 CME credits per issue.

Chapter 5 : WHO | Postpartum depression in India: a systematic review and meta-analysis

The direct evidence suggested that screening pregnant and postpartum women for depression may reduce depressive symptoms in women with depression and reduce the prevalence of depression in a given population, particularly in the presence of additional treatment supports (eg, treatment protocols, care management, and availability of specially.

Non-commercial uses of the work are permitted without any further permission from Dove Medical Press Limited, provided the work is properly attributed. This article has been cited by other articles in PMC. Abstract Postnatal depression PND has negative effects on maternal well-being as well as implications for the motherâ€"infant relationship, subsequent infant development, and family functioning. Given the possible intergenerational transmission of risk to the infant, the motherâ€"infant relationship is a focus for treatment and research. However, few studies have assessed the effect of treatment on the motherâ€"infant relationship and child developmental outcomes. Nineteen studies were selected for review, and their methodological quality was evaluated, where possible, effect sizes across maternal mood, quality of dyadic relationship, and child developmental outcomes were calculated. Finally, clinical implications in the treatment of PND are highlighted and recommendations made for further research. A recent review identified a number of postnatal factors placing women at increased risk to continued depressive symptoms, including younger maternal age, poor education attainment, historical episodes of depression, antidepressant use during pregnancy, child developmental problems, low parental self-efficacy, poor relationship, and the occurrence of stressful life events. The model by Milgrom et al 1 details vulnerability factors, precipitating factors including those factors which may trigger PND onset: The model also explains that sociocultural factors may play a role in exacerbating and maintaining PND and they account for heterogeneity in vulnerability to experiencing PND across women. An episode of PND generally lasts from 2 months to 6 months in duration and as long as 1 year in some cases. Notwithstanding, there are further cost implications in terms of child and adolescent services accessed due to the increased risk associated with having a parent with PND. Treatment is, therefore, a major public health concern and the one which spans both maternal and infant mental health. Following an episode of PND, women are predisposed to future risk of depressive episodes with subsequent children. Crucially, the first year is an important period for infants to develop self-regulatory skills. Interventions focusing exclusively on maternal depression may not be sufficient alone to buffer against the risks to infant development. Conceptualizing the depressive episode within the context of the perinatal period may promote adaptive developmental pathways in the infant. It is therefore necessary to measure outcomes in order to understand if interventions for PND exert a protective effect on the motherâ€"infant relationship and infant development in addition to maternal mood. Intergenerational transmission of risk to children of women with PND Goodman and Gotlib 37 highlighted the need for a developmental model, which explains the transmission and manifestation of vulnerability in infants. The nature of the association between PND and infant development is especially complicated by limited understanding of the full impact and risk of maternal mood and cognitions on infant developmental pathways. In their integrated model, Goodman and Gotlib 37 detail how the effects of PND are implicated across the intergenerational gap. Effect of PND on infant development Evidence suggests that PND in the parent may contribute to serious effects on infant cognitive and emotional development and is associated with later psychopathology and atypical development. However, effects varied with characteristics of children involved, including sex and contextual factors as indicated by the aforementioned model. They also suggested that timing and course of PND were more pervasive in their effects on child development. Research using the face-to-face video interaction paradigm has demonstrated that mothers with PND are more negative and their infants less positive than nondepressed motherâ€"infant dyads. They also found that full IQ scores were lower in children of mothers with PND, demonstrating the lasting effects of PND occurring early in the postpartum period. Recent systematic reviews by Kingston et al 45 and Kingston and Tough 46 evaluated longitudinal research of the effects of maternal distress, including postnatal distress, on infants and

school-aged children. They reported particular effects of postnatal maternal distress on both infant 45 and school-aged child 46 cognitive and socio-emotional development. They also summarized small-to-moderate effects of postnatal maternal distress on the behavior of school-aged children. The infantâ€"caregiver relationship has been widely recognized to play an important role in child development. Research by Stein et al 48 demonstrated that disturbances in maternal cognitions of women with PND may play a causal role in the negative effects on the motherâ€"infant relationship. Gerhardt 50 reviewed evidence that prolonged levels of cortisol in early infancy have consequences for neural systems implicated in how infants tolerate stress later in life, namely the prefrontal cortex and Hypothalamic-pituitary-adrenal axis. Emerging imaging research completed with adult children of women with PND captured a significant association between their attachment security at 18 months and neural responding at 22 years of age. Further research identified that compared with controls, women with PND are less able to identify happy faces potentially leading to decreased responsiveness toward their infants. This secure attachment, which develops between the mother and infant, also illustrates that the care the infant receives can impact in a protective manner on the developing child. Within the available literature, several approaches have been identified and have demonstrated variable levels of efficacy, including various antidepressant treatments, 55 , 56 antenatal group interventions, 57 psychoeducation, 58 , 59 cognitive behavior therapy CBT , 60 , 61 interpersonal psychotherapy IPT , 34 , 62 , 63 and interventions focusing on the motherâ€"infant relationship 64 â€" 66 and baby massage. The majority of reviews on the subject have explored efficacy in relation to maternal mood. Furthermore, there is emerging evidence that the treatment of PND alone is not sufficient to improve the motherâ€"infant relationship as well as child development. They do not reflect mechanisms or moderators proposed by Goodman and Gotlib. While there is an extensive literature of evaluation studies on various interventions for PND, little is known about the benefit of interventions to the quality of the motherâ€"infant relationship and moreover, child developmental outcomes. Poobalan et al 74 addressed this issue through an earlier review of treatments for PND, which focused on the motherâ€"infant dyad relationship. Outcomes were discussed in terms of child outcomes. They noted some support for dyadic-focused interventions in improving child outcomes; however, the evidence was equivocal. In contrast, the present review extends the review by Poobalan et al 74 by reporting on effect sizes, updating the search period from to , inclusion of other therapies antidepressant medication , and rigorous quality assessment, using the Clinical Tool for Assessment of Methodology CTAM 75 categories including allocation, assessment, control groups, analysis, and treatment. Most importantly, the present review considers the impact of treatments on maternal depression symptoms in addition to child outcomes. Method Search strategy The literature search included publications from to , since an earlier review by Poobalan et al 74 reviewed studies from the s to , using a standard assessment adapted from the Cochrane Collaboration and Jadad Scale. 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literature. Results The initial search returned articles. A further articles were excluded after more detailed examination of the title and abstract. Twenty-eight articles were removed for being duplicates or triplicates leaving 19 studies to be evaluated Figure 1 for a schematic diagram of the literature search. Only three studies 34 , 61 , 64 assessed both the quality of the dyad relationship and child outcomes. Although there was a high degree of heterogeneity across studies and measures used for assessment, effect sizes for different outcomes maternal mood, motherâ€”infant relationship, child developmental outcomes were calculated where possible.

Chapter 6 : Depression: Screening and Diagnosis - - American Family Physician

To review the efficacy of support groups and group therapy for women with postpartum depression within the first year after delivery. Searching Eight relevant databases were searched for articles published in English up until March

Group treatment for postpartum depression: The value of the review is limited by a lack of clarity in the review question, a basic synthesis and unclear study quality. Searching Eight relevant databases were searched for articles published in English up until March Search terms were reported. Reference lists of relevant records were searched manually. Study selection Both randomised controlled trials RCTs and non-randomised controlled trials that investigated a support group or group therapy using a psychological or psychosocial approach were eligible for inclusion. Interventions had to specifically target postpartum depression as defined using standardised measures and occurring during the first year after delivery. Interventions had to begin within the first year after delivery. Trials had to assess depressive symptoms or postpartum depression defined as before as a primary outcome. Studies of preventative interventions for postpartum depression were excluded. Mean participant age where stated ranged from Where reported, participants were mainly well educated, married or cohabiting middle class women. Various established measures were used at a range of time points to assess postpartum depression. Two trials included both depressed and non-depressed mothers. The start of the intervention where stated ranged from six weeks to 24 months after delivery. The original inclusion criteria were modified to include studies where intervention started later than one year post-delivery. Interventions included unstructured approaches, cognitive behavioural therapy, interpersonal psychotherapy as well as education, social support and workshops. Group sizes where stated ranged from four to 10 mothers. Treatment duration ranged from four to 14 weeks. All studies included weekly therapy sessions that ranged from 1. Control treatments included no intervention, waiting list controls and standard care. Some included trials compared different forms of therapy for example group versus individual therapy. Details of the study selection process were not reported. Assessment of study quality The Downs and Black checklist suitable for both RCTs and non-randomised controlled trials was used to assess the quality of the included studies. No details of the quality assessment process were reported. Data extraction Two reviewers extracted study characteristics, details on intervention and control groups, outcomes and results. Any disagreements were resolved through discussion. Methods of synthesis A narrative synthesis was used to summarise studies. Results of the review Six RCTs and five non-randomised controlled trials were included participating mothers, range 14 to Seven studies three RCTs did not have follow-up. Among the remaining four trials follow-up ranged from three to 12 months. Details of study quality were reported for each included trial but no overall evaluation of study quality was presented. Three RCTs reported appropriate, robust methods of randomisation. Nine studies six RCTs, three non-randomised controlled trials reported a decrease in depressive symptoms in mothers who received group therapy. Two non-randomised controlled studies reported mixed results with participants in the intervention group improving on some measures but not others. One of these studies included both depressed and non-depressed mothers. Four RCTs reported on remission rates: Three out of the four studies three RCTs, one non-randomised controlled study that included assessment at follow-up reported that benefits of group therapy emerged or continued at follow-up. One RCT had such high attrition that assessment at follow-up was not possible. Methodological limitations of the included studies reduced the validity of the presented results. CRD commentary The review question and the focus of the review were somewhat unclear due to the large variety of interventions investigated. It was unclear whether the review aimed to compare group treatment to usual care or to compare group versus individual treatments. The extension of inclusion criteria to include additional relevant studies was documented and seemed reasonable. The search strategy was clear but studies in languages other than English may have been missed. Independent duplicate processes were in place for data extraction and this reduced the risk of reviewer bias and error; it was unclear whether similar processes were used for study selection and quality assessment and if not this may

have introduced error and bias. Use of a narrative synthesis rather than a meta-analysis seemed appropriate given the variability between the included studies but limited quantitative results were presented and this made it difficult to gauge the clinical relevance of the findings. A thorough quality assessment of studies was conducted but the results of this were not reported clearly. It did not appear that study quality was taken into account in the synthesis. Implications of the review for practice and research Practice: The authors did not state any implications for practice. The authors recommend that future research focus on the efficacy of peer-support groups for women with postpartum depression and on the effect of including partners in the treatment of postpartum depression. Further, they recommended investigation of the level of therapist training and the timing of the group intervention. Direct comparisons between different types of treatment providers and also between different treatment approaches were recommended. Further recommendations were presented in the paper Funding Not reported.

Chapter 7 : Psychosocial and psychological interventions for postpartum depression | Cochrane

This systematic review of the prevention of postnatal depression shows that there is no clear evidence to recommend the implementation of antenatal and postnatal classes, early postpartum follow-up, continuity of care models, psychological debriefing in hospital, and interpersonal psychotherapy.

The existing trials on the long term effectiveness of cognitive behavior therapy CBT for the treatment of postpartum depression have conflicting results. Therefore, we performed a systematic review to summarize the current evidence. All peer-reviewed English-published randomized controlled trials were eligible if they assessed the long term at least at 24 weeks post partum effectiveness of CBT versus standard postpartum care for prevention of postpartum depression. Data from eligible studies were abstracted by using structured data extraction form and pooled for calculation of relative risk ratio. Five randomized controlled trials fulfilled eligibility criteria. In the included studies, the total number of women was with age ranged from 17 years to 42 years. Two trials had sample size less than Two out of five trials reported beneficial effect of CBT whereas three trials found no difference. However, these results showed effectiveness of intervention because of one large trial and excluding this trial, there was no significant difference. In this systematic review, we found a beneficial effect of CBT in the prevention of postpartum depression at 24 weeks of postpartum period. However, the evidence is limited by a small number of trials with results being dominated by a single large trial. Robust research with larger sample size is needed to determine the long-term effectiveness of CBT for treatment of postpartum depression. It is the most common complication of childbearing as it occurs approximately in one out of every eight deliveries [1]. PPD negatively affects health seeking behaviors of women not only for themselves but for their infants as well [3]. Studies have reported a low level of social engagement, slow physical growth, and high level of stress reactivity among children born to mothers with untreated PPD []. Various treatment options, pharmacological and non-pharmacological, are available for treatment of PPD [7]. Non-pharmacological treatment options are preferred in the postpartum period because of adverse effects of pharmacological agents in term of breast feeding []. Among non-pharmacological options, cognitive behavior therapy CBT is one of the effective treatment options for postpartum depression [11, 12]. Previous systemic reviews have examined the effectiveness of overall non-pharmacological interventions including psychosocial and psychological options not CBT specifically for PPD []. These reviews were also not focused to any specific postpartum time period in term of effectiveness of interventions. In addition, the available trials on CBT have reported conflicting results and most trials have limited sample sizes. The aim of this systematic review was to assess the effectiveness of CBT for postpartum depression at least at 24 weeks of postpartum period as compared to the provided standard postpartum care. This specific time period for long term effectiveness of CBT was chosen as most relapses are reported to occur in this period and raised questions over effectiveness of specific intervention [11, 12]. We searched three electronic databases, Medline, CINAHL and psycINFO, with search terms, cognitive behavior therapy, postpartum depression, postnatal depression, pregnancy, women, and standard postpartum care. These electronic databases contain original articles from subject of medicine, psychology and allied health sciences. The search was done from January to March to get most up to date information about chosen area. Search was carried out by using various combinations of key words including MeSH terms for interventions CBT , control routine care, postpartum care , outcome postpartum, postnatal and study design randomized controlled trials. Selection of studies for review was done in accordance with developed protocol which was approved by all authors after critical review. Along with electronic databases, reference and hand search of journals was carried out to identify studies that might have been missed from electronic search. We included all peer-reviewed randomized controlled trials RCTs published in English language. We limited our studies to RCTs as they are the gold standards for assessing effectiveness of an intervention. We included only those trials that had enrolled women with normal vaginal delivery and had postnatal depression. Trials in which women had twin

pregnancy, or had undergone instrumental or operative delivery were excluded because of higher risk of depression linked with these conditions as compared to normal vaginal delivery. We excluded trials with pharmacological intervention, psychodynamic therapy, non-directive counseling, behavioral therapy, or action therapy. The control in all the trials needed to be standard postpartum care given by either health visitors or community support workers, though there was a not exclusion criterion. The primary outcome considered for review was PPD at least at 24 weeks of postpartum period. Trials assessing the effectiveness of CBT at less than 24 weeks postpartum were excluded. The secondary outcomes considered for review include anxiety, stress, postpartum marital relationship and cost effectiveness of postpartum intervention. Two independent reviewers used a structured form for data abstraction and discrepancies were solved through discussion. Assessment of methodological quality: A qualitative analysis of the results of all included studies was performed to examine the long term effect of CBT on treatment of PPD and to explore the similarities and differences across studies. In meta-analysis quantitative data of the trials were pooled to estimate the effect size of CBT benefit. We assessed heterogeneity among studies by using I2 statistics and performing test for heterogeneity. Due to small number of studies, we did not examine publication bias. Figure 1 shows overall study selection stages. Table 1 shows reasons of studies excluded from the review []. Five of the trials [] fulfilled our eligibility criteria Table 2. Studies were published between and In four trials, randomization was at individual level [40,] whereas in one trial, it was at cluster geographical areas in which people registered with specific general practitioners level [41]. Total number of participants in included studies was Sample size ranged from 37 [44] to [41]. In the included trials [] effectiveness of CBT was compared with standard postpartum care. However, the duration of CBT sessions varied across trials. In three trials [44, 45] sessions were of one hour duration. There were differences in total length of intervention across trials. The total length of intervention in four trials was eight weeks [40, 41, 43, 44]. Of these four trials one [40] had three booster sessions at 6, 16 and 52 weeks of postpartum period. In one trial, length of intervention was up to ten weeks [42]. Studies varied in the personnel who delivered CBT and included health visitors [41, 43, 44], therapist [42], and research staff [40]. The comparator group in all included trials [] got standard usual postpartum care which included routine health visits by community nurses, health visitors and community support workers. The last assessment for outcome was performed at 24 weeks in two trials [43, 44] whereas in the remaining three trials it was done at 52 weeks [40], 72 weeks [41] and 60 months [42]. Secondary outcome including anxiety, postpartum marital relationship and cost-effectiveness of the intervention for postpartum depression were reported by two trials [41, 42]. Table 3 below summarized the methodological quality of included trials. Blinding of participants and personnel for intervention was maintained in one trial [40]. Similarly, there was no clear information about blinding of outcome assessment in trials [40,] except one [41]. Study power calculation was provided in only two trials [41, 42]. Two trials [41, 43] showed a significant positive effect of CBT sessions on postpartum depression at 24 weeks of postpartum period. In one trial [41], the proportion of participants with postpartum depression at 24 weeks of postpartum period was In the second trial [43] the proportion of participants with postpartum depression at 24 weeks of postpartum was Three trials [40, 42, 44] found no significant beneficial effect of CBT sessions over routine standard postpartum care provided by health visitors for prevention of postpartum depression at 24 weeks postpartum. Similarly, half of the women in intervention group could attend fewer than four sessions. This would have mitigated the effect of intervention. In the remaining two trials [42, 44] there was no effect of CBT session but trials had small sample sizes resulting in limited power. Effectiveness of CBT sessions was shown by statistically significant differences between the intervention and control groups in term of proportion of participants with postpartum depression at 24 weeks postpartum. Quantitative data was pooled from all included trials []. Meta-analysis revealed a statistically significant beneficial effect of CBT sessions as compared to standard postpartum care on long term management of postpartum depression. There was no statistically significant heterogeneity across studies. Although four of the five studies did not find a statistically significant benefit, the direction of overall effect size was in favor of CBT. Being small, these studies were not powered to discover a beneficial

effect of CBT. Lack of statistical heterogeneity is another indication that study results were generally pointing out the beneficial effect of CBT. There are certain limitations of this review, which need to be considered while interpreting findings. One trial [41] with large sample size had large weight Inclusion of studies published in English language only might have induced the reporting bias. Similarly, exploration of grey literature and contact with experts in field for unpublished data would have broadened the context of review. It may also be worthwhile to examine the effectiveness of CBT delivered by peers versus health visitors or support workers for postpartum depression. Similarly, importance of marital partner should be considered while designing intervention trials for postpartum depression as lack of social support and marital conflict contribute to the development of PPD. Focusing on depression in expectant and new fathers: Psychiatry Times ; Obstet Gynecol ; The effect of postpartum depression on child cognitive development and behavior: Arch Womens Ment Health ; 6: Maternal depression and child psychopathology: Clin Child Fam Psychol Rev ; Depression and anxiety in pregnancy. J Popul Ther Clin Pharmacol ; Maternal depression and anxiety across the postpartum year and infant social engagement, fear regulation, and stress reactivity. Peer support within a health care context: Int J Nurs Stud ; Efficacy of interpersonal psychotherapy for postpartum depression.

DOWNLOAD PDF SYSTEMATIC REVIEW OF CAREGIVER SUPPORT FOR THE TREATMENT OF A POSTPARTUM DEPRESSION

Chapter 8 : [Full text] Interventions for postnatal depression assessing the motherâ€“infa | IJWH

Postpartum depression Systematic review Group therapy Support group Group treatment Postpartum depression (PPD) is a common complication of childbirth, affecting an estimated 10% to 15% of women following the birth of a child (O'Hara and Swain).

Disclaimer Postpartum depression in India: Independent Researcher, New Delhi, India. Correspondence to Ravi Prakash Upadhyay email: Bulletin of the World Health Organization ; A systematic review of 47 studies in 18 countries reported a prevalence of Addressing these issues is therefore a priority for national governments and their international partners. The impetus for this will come from reliable scientific evidence of the burden of mental health problems and their adverse consequences. Dedicated maternal mental health services are largely deficient in health-care facilities, and health workers lack mental health training. The availability of mental health specialists is limited or non-existent in peripheral health-care facilities. Despite the growing number of empirical studies on postpartum depression in India, there is a lack of robust systematic evidence that looks not only at the overall burden of postpartum depression, but also its associated risk factors. Our current understanding of the epidemiology of postpartum depression is largely dependent on a few regional studies, with very few nationwide data. The current review was done to fill this gap, by providing an updated estimate of the burden of postpartum depression in India, to synthesize the important risk factors and to provide evidence-based data for prioritization of maternal mental health care. Any discrepancy in the search results was planned to be discussed with a third author AKR. We also searched the bibliographies of included articles and government reports on government websites to identify relevant primary literature to be included in the final analysis. For studies with missing data or requiring clarification, we contacted the principal investigators. Original research; published in the past 15 years; humans Study selection and data extraction For a study to be included in the systematic review, it had to be original research done in India, within a cross-sectional framework of a few weeks to 1 year post-birth. We excluded research done in a specific population, such as mothers living with human immunodeficiency virus; research including mothers with any current chronic disease. To have a fairly recent estimate of the burden of postpartum depression, we considered only studies published from the year and later. After initial screening of titles and abstracts, we reviewed the full text of eligible publications. Decisions about inclusion of studies and interpretation of data were resolved by discussion among the reviewers. Data from all studies meeting the inclusion criteria were extracted and tabulated. The selection category consists of parameters, such as representativeness of the sample, adequacy of the sample size, non-response rate and use of a validated measurement tool to gather data on exposure. The comparability category examines whether subjects in different outcome groups are comparable based on the study design and analysis and whether confounding factors were controlled for or not. The outcome category includes whether data on outcome s were collected by independent blind assessment, through records or by self-reporting. The outcome category also includes whether the statistical tests used to analyse data were clearly described and whether these tests were appropriate or not. In case of any discrepancy, a third author AP was consulted. Data analysis We did a meta-analysis of the reported prevalence of postpartum depression in the included studies. Heterogeneity between studies was quantified by the I2 statistic. In addition, the Edinburgh postnatal depression scale, which was used in the majority of studies we identified, can give false-positive results in the early postpartum period. We also did separate subgroup analyses on each of the following factors: Not all the studies provided data on the mean age of the study participants that was required for subgroup analysis; however, the proportion of mothers in specific age ranges were available. Using this information, we estimated the mean age of the study participants. For studies that reported the prevalence of postpartum depression in mothers at different time points, we used the prevalence reported in the earliest time point to reduce the effect of lost to follow-up. We used meta-regression analysis to identify factors contributing to the heterogeneity in effect size, i. We assessed

publication bias with the Egger test and used a funnel plot to graphically represent the bias. Finally, we listed the risk factors for postpartum depression. We used Stata software, version 14 StataCorp. Results Characteristics of the studies Of the articles we identified in our search, we screened titles of unique articles. Out of these, we reviewed relevant abstracts, assessed 62 full-text articles for eligibility and included 38 articles in our final analysis. The Edinburgh postnatal depression scale was the most commonly used study instrument 29 studies. Flowchart showing the selection of studies for the systematic review of the prevalence of postpartum depression, India, â€”