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THE EFFICACY OF INTERPERSONAL THERAPY AS A PSYCHOTHERAPEUTIC INTERVENTION IN THE TREATMENT OF POSTPARTUM DEPRESSION

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“Ring the bells that still can ring.
Forget your perfect offering.
There is a crack, a crack in everything.
That’s how the light gets in.”

Leonard Cohen

ABSTRACT

Postpartum Depression (PPD) is a serious depressive disorder that negatively affects some women, challenging their sense of identity in their newly altered reality, leaving them distraught and anxious, while they care for their new baby. PPD is a common but incapacitating condition that can, in some cases, be life-threatening. PPD has a profound impact on the patient, her baby, the mother-infant relationship and has further implications for her partner and wider family. PPD can be diagnosed if the patient is capable of disclosing how she is really feeling to her clinician. PPD is however, often undiagnosed and untreated. Biological and psychosocial risk factors for PPD have been identified in recent studies. Treatment for PPD is dependent on the severity of its symptoms and the patient's ability to function. PPD is a treatable disorder.

This dissertation examined Interpersonal Therapy as a treatment for PPD. This study explored IPT as a psychotherapy that presents the patient with a biopsychosocial model, as a way of understanding her situation. Findings endorse an emphasis on interpersonal dysfunction and conflict resolution in the present, making it a practical therapy, linking triggers to the patient's mood. This theoretical research has attempted to evaluate Interpersonal Therapy as a treatment for women with PPD. Findings of this study have revealed that IPT is an effective, but relatively new method of treatment for PPD. IPT is still in its infancy and has moved from clinical research to clinical practice in numerous countries around the world, including Ireland.

This research has concluded therefore, that IPT, as a new therapy, requires further research, if it is to be evaluated comprehensively in Ireland.

As a major public health issue, it is imperative that PPD is screened for, diagnosed and treated, to allow new mothers a more positive experience with their new babies.

CHAPTER ONE: INTRODUCTION

Pregnancy and the birth of a child is a momentous experience for most women, as it not only marks the entrance of her child into the world, but it is also an initiation of each woman into the realm of motherhood. For many, the pregnancy and subsequent arrival of a baby is a joyous and much anticipated occasion. It is an experience like no other, one for which no woman can be completely prepared. The bond between a mother and her child is a unique and extraordinary one. Each woman is no longer just someone's daughter, sister, partner or friend, but is now a child's mother and with that new status comes a whole new identity. The transition into motherhood is often accompanied by a variety of emotions. Feelings of joy and elation, pride, anxiety, doubt, exhaustion and stress are all very normal for the new mother, as she adjusts to her new role and embarks on a relationship with her new child. Often, lacking in confidence and with cultural and self-imposed expectations of herself, the experience for the new mother can seem, at times, overwhelming. For many mothers things get easier and settle down as time passes, but for a significant number of women, things do not.

Postpartum Depression, (PPD), (Tishby & Wiseman, 2014) is a serious depressive disorder that negatively affects some women, challenging their sense of identity in their recently changed reality; leaving them severely distressed, coping with feelings of inadequacy and anxiety and, at the same time, caring for a new baby. It has further detrimental implications for her partner, her baby and the entire family unit. The exact causes of PPD are not known but it is thought that a combination of biological, social and emotional factors play a part in its aetiology (Nedhari, 2011). PPD cannot be explained in purely biological terms, as not every new mother experiences postpartum depression.

Postpartum depression (PPD) represents a significant health problem for between 10% to 20% of women after delivery (Bobo & Yawn, 2014). Between 30% and 70% of these women with PPD may experience postpartum depression for a year or longer (Cutrona, 1982). Although emotional lability in the first few days following the birth of a baby can be attributed to hormone levels, (postpartum blues), a substantial amount of evidence would support the belief that protracted postpartum depression can be linked to episodes of stress both during the pregnancy and at time of delivery, and a lack of social support. A previous history of depression would also be seen as a good predictor of postpartum depression (Cutrona, 1982).

It is common for women to experience the 'baby blues' after the birth of a child. They usually begin around three days after the baby is born and may be accompanied by crying spells, increased feelings of vulnerability, sadness, irritability and mood swings. The baby blues although upsetting, normally pass within a few weeks (Bennett, 2013). Puerperal psychosis is the most extreme and rarest form of postpartum mood change. It affects 1 in 500 new mothers. Puerperal psychosis is a severe mental illness and usually requires hospitalization. PPD falls somewhere between the baby blues and puerperal psychosis. In clinical practice and research, PPD (i.e., nonpsychotic puerperal depression) is sometimes defined as depression that occurs within 4 weeks of childbirth or up to 12 months after childbirth (Stewart & Vigod, 2016).

PPD is the mood disorder that describes depressive episodes after childbirth and it is the most common postnatal neuropsychiatric complication (Bobo & Yawn, 2014). PPD is a common but debilitating condition and can, in some cases, be life-threatening. PPD is also easily diagnosed if the patient is capable of disclosing how she is really feeling to her clinician. It is

recommended that clinicians inquire with sensitivity about possible PPD symptoms at a postpartum consultation and that further comprehensive evaluation take place, if the patient presents with the core symptoms of depression, such as general loss of interest, irritability, extreme fatigue, tearfulness, etc. (Stewart & Vigod, 2016). PPD responds well to a variety of treatments that are effective for treating nonpuerperal major depression (Bobo & Yawn, 2014).

PPD affects 10% to 20% of women after delivery, irrespective of age, race or socioeconomic status. PPD can lead to a deterioration of maternal functioning and has negative implications for maternal bonding and child development (Bobo & Yawn, 2014). However, it is estimated that fewer than half of all cases are ever diagnosed, indicating a need for improving case detection, assessing risk factors, and the implementation of evidence-based treatment (Bobo & Yawn, 2014). It should be noted that the DSM-5 now classify major depressive episodes "with peripartum onset, encompassing cases with symptom onset during pregnancy or in the 4 weeks after delivery" (Bobo & Yawn, 2014).

Treatment for postpartum depression is dependent upon the severity of the symptoms and the level of functional impairment (Stewart & Vigod, 2016). PPD is a treatable disorder. Treatment options include the medical model, which recommends antidepressants as appropriate for more severe cases of PPD (Bobo & Yawn, 2014). Other preferred treatments are therapies such as, Interpersonal Therapy; Psychodynamic Psychotherapy; Cognitive Behavioural Therapy; Group Psychotherapy and Nondirective Counselling (Andrews Horowitz & Goodman, 2005).

The aim of this theoretical research is to explore the efficacy of Interpersonal Therapy as a psychotherapeutic intervention in the treatment of the client presenting with postpartum depression.

Specifically this research will:

1) Offer an exposition of Interpersonal Therapy as a psychotherapeutic treatment available to the client presenting with postpartum depression.

2) Present an evaluation of Interpersonal Therapy as a psychotherapeutic treatment available to the client presenting with postpartum depression.

CHAPTER TWO: AN EXPOSITION OF INTERPERSONAL THERAPY AS A PSYCHOTHERAPEUTIC INTERVENTION IN THE TREATMENT OF THE CLIENT PRESENTING WITH POSTPARTUM DEPRESSION

Options for the treatment of postpartum depression depend upon the severity of the woman's symptoms and her ability to function in relation to the care of her baby. Those with mild to moderate symptoms may be looked after in a primary care setting, with some psychosocial intervention and support. However, a psychiatric referral may be necessary for those whose symptoms do not respond to initial treatment and would be considered imperative in the case of severe illness, particularly if psychosis is present (Stewart & Vigod, 2016). Formal psychotherapy that addresses issues faced by the new mother as she transitions into motherhood is recommended (Stewart & Vigod, 2016).

IPT is grounded in the interpersonal theories of Harry Stack Sullivan and the attachment theories presented by Bowlby and others. IPT is based on the belief that people who experience social disruptions are more at risk of developing depression (Stuart & O'Hara, 1995). IPT explicitly targets patients' interpersonal relationships as a point of intervention and is constructed to help patients in adapting their relationships and/or their expectations regarding their relationships (Stuart & O'Hara, 1995). IPT for PPD uses Engel's biopsychosocial model which states that biological, psychological and social elements combine with the person to produce a unique diathesis and response to stress (Scott, 2012). The patient is presented with this biopsychosocial model as an explanation for her distress (Scott, 2012). This more comprehensive approach allows the patient view PPD as not just an illness and encourages work with the therapist to develop ways of dealing with the factors that contribute to her distress.

Postpartum depression is linked with interpersonal problems and the puerperium is a period of major role transition (Stuart & O'Hara, 1995). IPT focuses specifically on the effects of depression on interpersonal functioning; this focus makes IPT a potentially practical psychosocial treatment for postpartum depression (Stuart & O'Hara, 1995). IPT makes no assumptions about the causes of depression but treats depressive symptoms and problems with interpersonal relating as a starting point and the focus of treatment.

IPT as an acute treatment generally has three stages: (1) diagnosis assessment, psychiatric/social history (including actual social functioning, personal relationships, their behavioural patterns and mutual expectations), and the connection between the present interpersonal position within one of four interpersonal problem areas (i.e., grief, interpersonal role disputes, role transitions, or interpersonal deficits), to establish a treatment framework; (2) employment of strategies (defined in the IPT manual) that will be distinctly related to the particular interpersonal dysfunction; and (3) encouragement to recognise and build upon therapeutic gains to develop ways of identifying and countering future depressive symptoms (Dennis, 2003).

IPT is modified for use with women with PPD. Common symptoms experienced by postpartum women are feelings of exhaustion due to sleep deprivation, low energy and at times feelings of being overwhelmed. These feelings and symptoms are often natural consequences of transitioning into a new role that is demanding, fulltime and not always supported. They do not necessarily indicate PPD.

The patient's depressive symptoms are placed in an interpersonal context as an interpersonal inventory is taken (Stuart & O'Hara, 1995). The inventory's focus is the mother's

expectations before birth. These include her expectations around social support from partner, family and friends. Information gathered illustrates how she relates to significant people in her life and includes expectations of the parties in those relationships. The patient is encouraged to relate both satisfactory and unsatisfactory aspects of each relationship and the ways in which, ideally, she would like them to change. This inventory includes the mother's feelings in relation to motherhood, her baby and their relationship. Details are sought regarding the planning of the pregnancy, the pregnancy itself, the labor and birth of the child (Stuart & O'Hara, 1995).

The therapist works with the patient to identify a particular problem area, with a specific focus. Once the specific focus has been established, the patient is provided with an explanation of IPT, including a reason and direction for the treatment. The therapist participates actively in the relationship and emphasizes the interpersonal nature of the therapy. When the four problem areas are explained to the patient, they are illustrated by examples previously given by the patient in their inventory, amplifying both their relevance and pertinence.

The patient is informed that IPT is an effective form of treatment for depression within a specific time frame. There are expectations of the patient within this therapeutic relationship. The patient is expected to talk openly about her relationships with others and the problems associated with them. In the first session of IPT, the patient-therapist contract is discussed in detail, a 12-session limit is set, a schedule of appointments and their frequency is decided. Before the session concludes, the therapist briefly summarizes the session for the patient (Stuart & O'Hara, 1995).

Every subsequent session begins with the therapist enquiring about the events of the past week, particularly regarding the problem area that was discussed in the previous session. This enquiry encourages focus on the patient's part to actively participate in their treatment and to become an active agent for change in their lives. This message reinforces that she is both responsible for changing her behaviour and that the power is within her, to positively affect her relationships (Stuart & O'Hara, 1995). The second session focuses on completing the interpersonal inventory, on explicit problem areas particularly. This exercise is not merely data collection but a definitive attempt to distinguish particular areas that are problematic in the patient's relationships. At the end of the second session both therapist and patient have a clear direction and specific focus going forward.

Treatment in the ensuing sessions should have one of the four IPT problem areas as their central focus, such as, role transitions, interpersonal disputes, grief, and interpersonal deficits. (Stuart & O'Hara, 1995). Defining PPD as a role transition is useful in several ways. Firstly, it provides the patient with a fundamental reason for, and a way of understanding their particular problems. There is also the implication that their depression will be time-limited (Stuart & O'Hara, 1995).

Role Transitions in the postpartum period involves adapting to a new role, learning new skills, increased responsibilities, more stress and less sleep, while maintaining existing responsibilities and relationships. The patient often feels that they are being pulled in many directions in their attempts to juggle increasing demands, resulting in low self-esteem and confusion around roles, relationships, responsibilities and priorities. The aim of the IPT therapist is to help the patient combine her new role with those already established. With the encouragement of the therapist the patient can discuss and examine her feelings and

emotions, both positive and ambivalent towards each of the roles. A more balanced and pragmatic view of each role allows for a modification of expectations and a reframing of priorities. A reframing of priorities and commitments can facilitate time to adapt.

Following the comprehensive review, the patient is encouraged to focus on a particular problem area and brainstorm to suggest and examine possible solutions with a view to creating a plan of action and thereafter review the consequences of the plan. Possible solutions may include asking her partner for more assistance with childcare or household chores or may involve asking extended family for more help. What is important is not the actual solution but that the patient learns that by assessing her interpersonal relationships, she can empower herself to change the problematic aspects of her life (Stuart & O'Hara, 1995).

Regarding Interpersonal Disputes, one of the most distressing can be that of the patient and her partner. Assessing the patient's expectations of herself and her partner around childcare and the roles each would play should be focused on specifically. Other significant relationships should also be examined, including parents, in-laws and other children. The therapist assists the patient in modifying her expectations of her partner, adopting a more balanced view around the newborn and establishing new sources of support (Stuart & O'Hara, 1995). Including the partner in one or two therapy sessions gives the therapist a clearer picture and an opportunity to observe the couple during interactions can be helpful in working through interpersonal disputes. Often couples achieve insight into how the problem is viewed by the other partner which allows them appreciate the role transitions that must be undergone by their partner, during the postpartum period (Stuart & O'Hara, 1995).

Grief is another problem area that may coincide with the postpartum period and can bring up profound issues for the new mother. Grief can be the result of the death of a newborn or a significant other during the neonatal period. Grief and responses to it may have been deferred if the loss of a significant other occurred during the pregnancy. The therapeutic aims here allow the patient to mourn the loss and assist the patient in establishing new relationships to replace those lost relationships (Stuart & O'Hara, 1995).

Interpersonal Deficits is the fourth problem area to be addressed by the mother experiencing PPD. The attachment between the mother and her newborn is crucial to the development of the baby, it's sense of security and safety, and to their developing relationship. The therapist educates the patient in relation to the care of her baby and child development; to practice interpersonal skills with a view to developing other relationships and seek out further social supports for themselves going forward (Stuart & O'Hara, 1995).

The techniques used by the IPT therapist are used for all types of depression but there are additional ones specifically employed for the patient with PPD. The most common technique used is psychoeducation. The therapist not only provides information and education around PPD itself but informs and educates in relation to care of the newborn and child development, which increases the understanding of the patient with PPD of their own situation. Communication analysis is another technique useful in conjoint sessions as it elucidates areas where communication is breaking down or is ambiguous and misleading. Although the therapist in sessions is directive, it is recommended that he/she refrain from imparting advice. The goal is to promote development of the patient's problem-solving skills and as a consequence, find their own solutions (Stuart & O'Hara, 1995).

From the beginning of treatment, the patient with PPD should be aware that the aim of the process is to assist them in their recovery by using new skills and techniques that make relapse less likely in the future. Termination of the therapy should be discussed clearly with the patient during the last sessions so that they are well prepared for the event. By acknowledging that the therapy will end, the patient is prepared and given an opportunity to grieve this loss too, if necessary, but also a confidence that they have new skills and resources in place to help them function independently and competently in their new role as mother (Stuart & O'Hara, 1995).

CHAPTER THREE: AN EVALUATION OF INTERPERSONAL THERAPY AS A PSYCHOTHERAPEUTIC INTERVENTION IN THE TREATMENT OF THE CLIENT PRESENTING WITH POSTPARTUM DEPRESSION

Postpartum depression is a common disorder that can profoundly impact both mother and baby. There are verifiable treatments for perinatal depression and PPD. One of the most prominent is Interpersonal Therapy. The transition from pregnancy to motherhood can be a distressing and challenging time for the woman experiencing PPD. Adjusting to a new reality which often differs from the expectations of it, with the added complication of PPD, can make this metamorphosis a disturbing and frightening experience. Interpersonal Therapy as a psychotherapeutic intervention seeks to help clients understand their condition in biological, social and psychological terms, with the aim of alleviating the psychological distress caused by PPD, during this time of transition.

Women with PPD often describe significant differences between the social support they actually receive postpartum and that which they feel they need and would prefer. This perception can extend to some or all of their interpersonal relationships but is most often highlighted in relation to their partner. This perceived absence of support is considered a risk factor for the occurrence of PPD (Scott, 2012). IPT specifically targets interpersonal issues experienced by women with PPD making it suitable for postpartum women and their partners. IPT is an optimal treatment for women with PPD for whom role transition is a particular concern (Misri & Kendrick, 2007). As both a poor support and relationship disruptions can make women more vulnerable to PPD, IPT is considered an effective treatment compatible with countering PPD (Dennis & Hodnett, 2007).

For women with PPD, choosing a treatment for severe depression can be problematic, with limited research in relation to psychotherapy, medication or a combination of both, to help them with their decision. It is thought that the effectiveness of antidepressant medication and the woman's ability to tolerate it should be no different to non-pregnant MDD, but the evidence base is limited (Abreu & Stuart, 2005). Recent analysis of research would indicate effectiveness but many of the studies did not include women who were breastfeeding, and no study was a randomized and controlled trial (Scott, 2012). Many women are also concerned about the possible effects of antidepressant medication on their baby if they are breastfeeding (Fitelson, Kim, Scott Baker, & Leight, 2011). Concerns of mothers with PPD around antidepressant use include, breastfeeding, possible side effects, damaging long-term effects as well as the stigma linked to the use of medication (Scott, 2012). For this reason, a psychotherapeutic intervention such as Interpersonal therapy is preferable for most women.

There is considerable evidence to support the use of IPT as seen in two meta-analyses of psychological interventions for PPD. The first demonstrated that IPT for PPD has a significant effect size; the second showed that therapies for PPD that used Interpersonal techniques has a larger effect size than those using cognitive techniques (Scott, 2012). In comparative tests and trials, IPT was compared with a waiting list control and scored higher on the Beck Depression Inventory and the Hamilton Rating Scale for Depression; women using IPT had substantially better recovery rates also (Scott, 2012). Likewise, in another study which followed women who received IPT prior to the birth of their baby and continued with the treatment post-birth, findings revealed considerably better results in comparison to usual treatment (Scott, 2012). "Treatment as usual" invariably involves antidepressant medication or generalized counselling and may not be sufficient in addressing the very particular needs of the women with PPD (Klier, Muzik, Rosenblum, & Lenz, 2001). Different

psychological/psychosocial treatments accessed weekly have been found efficacious for those with PPD, these include interpersonal therapy (McQueen, 2008). The British Medical Journal has recognized IPT as a successful intervention alternative to a pharmacologic approach in treating women with PPD (McQueen, 2008). Seven studies were undertaken to determine the effectiveness of IPT in the prevention of PPD (Werner, Miller, Osborne, Kuzava, & Monk, 2015). Four of these randomized controlled trials showed a contraction in the probability of the women developing PPD (Werner et al., 2015). The women selected for these trials were deemed to be at risk for PPD. IPT was specifically chosen as it uses as its focus interpersonal relationships and disruptions relating to same, which are the psychological risk elements for PPD. The IPT approach made it a good fit for PPD prevention (Werner et al., 2015). Another positive factor of this approach was that it was delivered by non-medical personnel which makes the treatment more versatile and adaptable to a variety of contexts (Werner et al., 2015).

IPT has had success when delivered in a group setting (Scott, 2012). IPT was first modified for use in a group situation for those with Bulimia (Klier et al., 2001). Delivery of IPT in a group format is seen as especially efficacious as it includes an immediate support network which can be accessed during treatment. When used in a group format, IPT allows members to address their interpersonal difficulties within the group setting. This method of treatment can be beneficial for those women who feel socially isolated and lack a supportive network, as it provides both social support and empathy (Klier et al., 2001). The group setting allows members see their personal circumstances in a more universal way as they identify with the struggles of others, in terms of interpersonal relationships and role transition. Likewise, it normalizes the individual's problems and experience by affording them the opportunity to also see the similarities between them (Klier et al., 2001). In the group setting, it is the group

that is active and supportive, as the therapist is, in individual therapy. As well as offering participants a new support system and encouragement, IPT in a group setting offers its members an opportunity to develop communication skills which can be translated to their personal relationships and the possibility to explore issues of conflict they may be experiencing (Klier et al., 2001). Of the women who completed the treatment in one study (Klier et al., 2001), most showed considerably reduced symptoms of depression (Klier et al., 2001).

IPT is an effective treatment for PPD because of its versatility. It can be adapted for use in many settings, including individual therapy, couple therapy, group and community settings as well as for use in hospital and healthcare settings and telephone IPT (Kaur Kang, 2020). IPT is an efficient, definitive, issue-focused, time-limited therapy, which can be delivered by a variety of organizations and specialists, trained in IPT (Grigoriadis & Ravitz, 2007). The positive advantages of IPT as a treatment for PPD are that it is evidence-based and uses as its focus, the universally experienced issues of many women with PPD, including role transition, loss and conflict (Grigoriadis & Ravitz, 2007). The aims and specific techniques of IPT are published and available in manuals which coherently elaborate on the objectives of the treatment and its techniques (Grigoriadis & Ravitz, 2007). The WHO has recommended that evidence-based psychological treatments such as IPT, should be included in a front-line approach to the treatment of pregnant and breast-feeding women with moderate to severe PPD (Kaur Kang, 2020). Both the Canadian Psychiatric Association and the American Psychiatric Association in their guidelines for depressive disorders, recommend IPT as a treatment effective in dealing with depressive symptoms (Grigoriadis & Ravitz, 2007).

In relation to interpersonal relationships, there exists compelling data confirming that women who have positive social and partner support are less inclined to develop PPD as these supports are protective elements (Yim, Tanner Stapleton, Guardino, Hahn-Holbrook, & Dunkel Schetter, 2015). These women have higher self-esteem and confidence when negotiating a period of transition and adapting to new roles (Yim et al., 2015). Interpersonal therapy focuses on interpersonal relationships and role transitions which make it an appropriate therapy for this specific condition. Both individual and group interpersonal therapy, which concentrates on role transition and conflict resolution within close relationships have achieved promising results in reducing PPD (Yim et al., 2015).

Although IPT has received some empirical testing, as an established psychotherapy it is still in its infancy. A disadvantage of IPT is that there is an expectation that the patient is actively involved in their treatment. The treatment demands that the patient employs new ways of behaving if it is to work well. Severely depressed mothers may not be capable of this kind of active participation. Detractors state that the focus of IPT is too limiting in its concentration on interpersonal problems and does not address intrapsychic struggles (Bea & Tesar, 2002).

IPT is a comparatively young psychotherapy employed for use with specific psychiatric disorders (Markowitz & Weissman, 2004). Much is not known about its suitability for some diagnoses, its optimal dosing, how it works with pharmacologic strategies, its use in alternative compositions etc. (Markowitz & Weissman, 2004). Although there has been much research done regarding IPT as an intervention, it is only beginning to expand into medical practice. (Markowitz & Weissman, 2004). IPT is considered a simple intervention for pracitised psychotherapists to learn, however, its efficacy when delivered by less experienced therapists is unproven (Markowitz & Weissman, 2004). Impediments exist to women

accessing any kind of psychotherapy, including IPT. These can include the perceived stigma around mental health, lack of access to a trained IPT therapist, childcare issues as well as the time and cost implications (Pearlstein, Howard, Salisbury, & Zlotnick, 2014).

Much verifiable research exists in relation to PPD and the risk factors associated with it, but enquiries tend to focus on one contributory element rather than a more integrated approach, which includes both biological and psychosocial elements. This lack of cohesion means that biopsychosocial systems and interplay remain impoverished and unproven (Yim et al., 2015). Further research which amalgamates biopsychosocial inquiry of bigger sample size are required to further our understanding of PPD aetiology (Yim et al., 2015).

There is very little research available on the use of IPT for PPD within a specifically Irish context. This may be due to the fact that IPT is a relatively young psychotherapy in Ireland with a smaller cohort of psychotherapists specializing in the area. The College of Psychiatrists of Ireland have stated on record, that there is robust evidence supporting IPT as an efficacious treatment of depression, on its own and combined with antidepressant medication (Ireland, 2019). The 'Vision for Change' mental health strategy document in Ireland, has recognized the need to prioritise maternal mental health (Leahy-Warren, Dec 2013 / Jan 2014). The delay in diagnosis and treatment of PPD is considered to be the most important feature in the duration of postpartum depression (Leahy-Warren, Dec 2013 / Jan 2014). Treatment methods that combine psychotherapy and psychopharmacology with a holistic dimension for mothers with PPD have been proven to be efficacious (Leahy-Warren, Dec 2013 / Jan 2014). Further research on the use of Interpersonal Therapy for postpartum depression is essential if the therapy is to be evaluated comprehensively in Ireland.

CHAPTER FOUR: CONCLUSION

Postpartum depression (PPD) negatively impacts the health and welfare of many new mothers, their babies, partners and their families. In the U.S. alone, there are over four million live births every year (Werner et al., 2015). Approximately 800,000, or 20%, of these new mothers will suffer either a major or minor depressive episode (Werner et al., 2015). PPD is the most common complication associated with new mothers; it is more common than gestational diabetes (3-8%) and preterm birth (12.3%) (Werner et al., 2015). Its impacts and effects are far-reaching and are linked with relationship conflict, functional ability – both occupational and social, and most importantly, the mother-infant relationship, which is paramount. There is an overwhelming amount of research which testifies to the adverse effects of PPD on the development of the infant, both cognitively and emotionally and on the mother-infant relationship.

Studies into the biological elements that impact the aetiology of PPD are only in their infancy (Werner et al., 2015). However, there are many identified psychical and societal risk factors (Werner et al., 2015) with gestational depression the most recognized predictor of PPD (Werner et al., 2015). PPD is an important public health issue for many women from different backgrounds and cultures, yet it is frequently undiagnosed and therefore not always treated (Dennis, 2003).

PPD often goes untreated due to the stigma associated with the condition (Werner et al., 2015). Many women feel reluctant to disclose their mental health concerns to others over fears of being labelled a bad/unfit mother, fear of losing her baby or just feeling that she should be happy at a time when she is severely distressed. A reluctance to use

antidepressants when breastfeeding can also contribute to a new mother's unwillingness to disclose how she is actually feeling. The impacts of PPD indicate preventative action is justified (Dennis, 2003). Addressing identified elements of risk may reduce the probability of developing PPD (Dennis, 2003). To date, this approach has only been partially successful, as risk elements have not been assessed from a comprehensive biopsychosocial perspective and further research is needed in this area. Screening during pregnancy is of vital importance if women are to be offered preventative treatments but this screening must be culturally sensitive (Dennis, 2003), easily managed and understood, and part of an ante and postnatal process. Studies indicate that PPD can be predicted and managed successfully with both preventative measures and therapeutic treatment and also support the implementation of a comprehensive screening approach (Dennis, 2003). PPD is a treatable disorder which can and does respond to both pharmacological and psychotherapeutic treatments.

Interpersonal therapy is a time-limited psychotherapy which emphasizes the present and concentrates on the interpersonal aspect of the depressive symptoms (Werner et al., 2015). IPT makes no assumptions about the causes of depression. The psychoeducation element of IPT means the patient has a clear explanation of the treatment, including a reason for and direction of the treatment. By focusing on role transitions and interpersonal deficits, the patient gains a better understanding and ultimately control of her situation. The patient is empowered to take responsibility for her behaviour and become an active agent in her own life, so as to positively affect her relationships. Using techniques such as communication analysis allow the patient to understand where breakdowns in communication occur and to develop new skills in dealing with the issues that arise. Developing confidence in communication and problem solving motivates and encourages patients to move forward with their lives and makes relapse less likely.

IPT is an effective treatment that lends itself well to a group setting. It offers women a support network which normalizes the issues they are all experiencing. The peer support offered by a group setting is beneficial for those women who feel socially isolated and lacking in support. It allows women develop essential skills in communication and conflict resolution which they can translate and adapt for use in their own lives. IPT is therefore an effective treatment for PPD and its versatility makes it a very practicable option. IPT is an efficient, definitive, issue-focused, time-limited therapy which can be delivered by a variety of organizations and specialists trained in IPT (Grigoriadis & Ravitz, 2007).

What has become evident during the course of this research is that there is a lack of comprehensively integrated studies that include all the factors involved in PPD, highlighting that further research which integrates a biopsychosocial inquiry of bigger sample size is required, if we are to better our understanding of this debilitating condition and its aetiology. Within an Irish context, there is a dearth of research available on the use of IPT for PPD. Further research on the use of Interpersonal Therapy for postpartum depression is crucial, if the therapy is to be evaluated comprehensively in Ireland.

Postpartum depression is a debilitating and distressing condition that negatively affects a significant number of new mothers. The effects of PPD on the mother-infant relationship and the child's cognitive and emotional development have been well documented. It has further negative implications for her partner, the wider family and her interpersonal and social functioning. Women should not be robbed of what should be a time of great joy and celebration. The postpartum period is such a short and precious time of bonding for mother and infant, but when this time is dominated by the new mother's postpartum depression, the effects can be devastating and last a lifetime.

Bibliography and References

Abreu, A. C., & Stuart, S. (2005). Pharmacologic and Hormonal Treatments for Postpartum Depression. Psychiatric Annals, 568-576.

Andrews Horowitz, J., & Goodman, J. H. (2005). Identifying and Treating Postpartum Depression. Journal of Obstetric, Gynecologic & Neonatal Nursing (JOGNN) Vol. 34, 264-273.

Bea, S. M., & Tesar, G. E. (2002). A primer on referring patients for psychotherpay. Cleveland Clinic Journal of Medicine, Volume 69, 113-127.

Bennett, E. D. (2013). Article 24 Postpartum Depression: What Counselors Need to Know. Retrieved from VISTAS Online: http://www.counseling.org/library/

Bobo, W. V., & Yawn, B. P. (2014). Concise review for physicians and other clinicians: postpartum depression. Mayo Clinic Proceedings June 2014 Vol. 89 Issue 6, 835.

Cutrona, C. E. (1982). Nonpsychotic postpartum depression: A review of recent research. Clinical Psychology Review, 487-503.

Dennis, C. L. (2003). Detection, Prevention and Treatment of Postpartum Depression. Faculty of Nursing University of Toronto, University Health Network Women's Health Program 2003, 111.

Dennis, C. L., & Hodnett, E. D. (2007, October 17). Psychosocial and psychological interventions for treating postpartum depression. Retrieved from Cochrane Database of Systematic Reviews: https://doi.org/10.1002/14651858.CD006116.pub2

Fitelson, E., Kim, S., Scott Baker, A., & Leight, K. (2011). Treatment of postpartum depression: clinical, psychological and pharmacological options. International Journal of Women's Health, 1-14.

Grigoriadis, S., & Ravitz, P. (2007). An approach to interpersonal psychotherapy for postpartum depression. Canadian Family Physician , 1469-1475.

Ireland, C. o. (2019, February 7). Depression in Ireland - where do we stand today? Retrieved from https://www.medicalindependent.ie/category/cpi

Kaur Kang, H. e. (2020, February 25). PROTOCOL: Effectiveness of interpersonal therapy to other pyschological and pharmacological interventions for reducing depressive symptoms in women diagnosed with postpartum depression in low and middle-income countries: A systematic review. Retrieved from Campbell Systematic Reviews: https://doi.org/10.1002/cl2.1074

Klier, C., Muzik, M., Rosenblum, K., & Lenz, G. (2001). Interpersonal Psychotherapy Adapted for the Group Setting in the Treatment of Postpartum Depression. The Journal of Psychotherapy Practice and Research, 124-131.

Leahy-Warren, P. (Dec 2013 / Jan 2014). Postnatal depression: risk factors, assessment, identification and treatment. World of Irish Nursing WIN, Vol 20 (10), 51-54. Retrieved from Clinical Focus.

Markowitz, J. C., & Weissman, M. M. (2004). Interpersonal psychotherapy: principles and applications. World Psychiatry, 136-139.

McQueen, K. e. (2008). Evidence-Based Recommendations for Depressive Symptoms in Postpartum Women. JOGNN, 127-136.

Misri, S., & Kendrick, K. (2007). Treatment of Perinatal Mood and Anxiety Disorders: A Review. The Canadian Journal of Psychiatry, Vol. 2, 489-498.

Nedhari, A. (2011). Examining Postpartum Depression Symptoms and Treatment. Inquiries Journal/Student Pulse, 3 (08).

Pearlstein, T., Howard, M., Salisbury, A., & Zlotnick, C. (2014, February 10). Postpartum Depression. Retrieved from HHS Public Access Author Manuscript: 10.1016/j.jog.2008.11.033

Scott, S. (2012). Interpersonal Therapy for Postpartum Depression. Clinical Psychology & Psychotherapy, Vol. 19, Issue 2.

Stewart, D. E., & Vigod, S. (2016). Postpartum Depression. The New England Journal of Medicine, 2177-2186.

Stuart, S., & O'Hara, M. W. (1995). Interpersonal Psychotherapy for Postpartum Depression A Treatment Programme. The Journal of Psychotherapy Practice and Research, 18-29.

Tishby, O., & Wiseman, H. (2014). Types of countertransference dynamics: An exploration of their impact on the client-therapist relationship. Psychotherapy Research, Vol.24, Issue 3, 360-375.

Werner, E., Miller, M., Osborne, L., Kuzava, S., & Monk, C. (2015). Preventing postpartum depression: Review and recommendations. Arch Womens Mental Health, 41-60.

Yim, I., Tanner Stapleton, L., Guardino, C., Hahn-Holbrook, J., & Dunkel Schetter, C. (2015). Biological and Psychosocial Predictors of Postpartum Depression: Systematic Review and Call for Integration. The Annual Review of Clinical Psychology, 99-128.