Interpersonal Psychotherapy to Reduce Psychological Distress in Perinatal Women: A Systematic Review

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Abstract: Background: Interpersonal psychotherapy (IPT) is a psychological intervention with established efficacy in the prevention and treatment of depressive disorders. Previous systematic reviews have not evaluated the effectiveness of IPT on symptoms of stress, anxiety, depression, quality of life, relationship satisfaction/quality, social supports, and an improved psychological sense of wellbeing. There is limited information regarding moderating and mediating factors that impact the effectiveness of IPT such as the timing of the intervention or the mode of delivery of IPT intervention. The overall objective of this systematic review was to evaluate the effectiveness of IPT interventions to treat perinatal (from pregnancy up to 12 months postpartum) psychological distress. Methods: MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily (Ovid), EMBASE (Ovid), PsycINFO (Ovid), Cochrane Central Register of Controlled Trials (OVID), CINAHL with Full Text (Ebsco), Social Work Abstracts (Ebsco), SocINDEX with Full Text (Ebsco), Academic Search Complete (Ebsco), Family & Society Studies Worldwide (Ebsco), Family Studies Abstracts (Ebsco), and Scopus databases were searched from inception until 31 January 2019. Two researchers independently screened articles for eligibility. Of the 685 screened articles, 43 met the inclusion criteria. The search was re-run on 11 May 2020. An additional 204 articles were screened and two met the inclusion criteria, resulting in a total of 45 studies included in this review. There were 25 Randomized Controlled Trials, 10 Quasi-experimental studies, eight Open Trials, and two Single Case Studies. All included studies were critically appraised for quality. Results: In most studies (n = 24, 53%), the IPT intervention was delivered individually; in 17 (38%) studies IPT was delivered in a group setting and two (4%) studies delivered the intervention as a combination of group and individual IPT. Most interventions were initiated during pregnancy (n = 27, 60%), with the remaining 18 (40%) studies initiating interventions during the postpartum period. Limitations: This review included only English-language articles and peer-reviewed literature. It excluded government reports, dissertations, conference papers, and reviews. This limited the access to grassroots or community-based recruitment and retention strategies that may have been used to target smaller or marginalized groups of perinatal women. Conclusions: IPT is an effective intervention for the prevention and treatment of psychological distress in women during their pregnancy and postpartum period. As a treatment intervention, IPT is effective in significantly reducing symptoms of depression and anxiety as well as improving social support, relationship quality/satisfaction, and adjustment. Systematic Review Registration: PROSPERO CRD42019114292.
Keywords: systematic review; interpersonal psychotherapy; antenatal; perinatal; postpartum; women; distress

1. Background

The perinatal period is a time of increased social, emotional, biological, and psychological adjustments for women [1,2]. Pregnancy and the first 12 months postpartum is a developmental life stage for women which requires adjustments to changes in their physical appearance and expectations for new responsibilities [3,4]. As such, perinatal women are at increased susceptibility to psychological stress and alterations in perceived wellbeing [5,6]. Psychological distress, including stress, anxiety, and depression, resulting from pregnancy and the postpartum period is common, occurring in 15% to 25% of perinatal women [7,8]. The impact of perinatal stress, anxiety, and depression is far reaching and associated with impaired mother-fetal/infant relationships, obstetrical complications, and child cognitive-developmental problems [9,10]. Left untreated, approximately 40% of these women will have symptoms that persist until their children enter the school system [11,12]. Unfortunately, perinatal stress, anxiety, and depression often go undetected and untreated [13–15]. Effective treatment of perinatal mental health concerns is imperative.

Interpersonal psychotherapy (IPT) is considered a highly effective treatment for anxiety and depression [16–18]. Studies examining the efficacy of IPT during the perinatal period appear promising [19–21]. Stuart and O’Hara (1995) [22] reported that IPT is well-suited to the needs of perinatal women as IPT focuses on four areas that are significant factors in the prediction and maintenance of perinatal mental health concerns. These factors include role transitions, interpersonal disputes, grief and loss, and interpersonal deficits [22]. First, consistent with the focus of IPT, role transitions associated with becoming parents correlate with perinatal mental health symptoms and resulting interpersonal relationship disputes [23–25]. Secondly, interpersonal disputes are one of the most significant stressors for couples during the perinatal period. Next, grief and loss during the perinatal period are also a focus of IPT [22]. Finally, interpersonal deficits, in particular low social support and marital discord, are strongly associated with perinatal anxiety and depression [26,27].

IPT is an intervention aimed at alleviating psychological symptoms, coping with problems due to loss, change, and relationship conflict, thereby improving interpersonal functioning [25,28]. It is based on the concept that when faced with adversity, factors such as attachment styles, communication patterns, and the quality of social support networks contribute considerably to an individual’s range of symptoms of psychological distress [25]. Conceptualizations of social supports come from work on attachment theory, trust, and coping in times of adversity [29]. These social supports play an important role in how individuals navigate the coping process and manage stress [30,31]. Social supports vary in type and can include emotional support, practical help, social companionship, and motivational support [32]. Emotional support offers reassurance about individuals’ self-worth, unconditional positive regard, and the opportunity for confiding [29,32]. Practical help, also known as instrumental or tangible support, provides direct assistance [32,33]. Social companionship is important as it facilitates individuals engaging in leisure activities [32]. Motivational support is defined as help that supports an individual’s plan or goals [34]. IPT endeavours to improve attachment security, interpersonal change, and psychological distress [25,35] as a mechanism for improving individual coping and resilience.

In addition to the four salient areas of focus, IPT is consistent with many women’s desire to self-manage their mental health concerns [36,37]. While the literature suggests that psychological therapy is effective, perinatal women report significant barriers to seeking psychological support. These barriers include stigma (self and by their healthcare professional), uncertainty about whether their symptoms are normal or abnormal, inability to articulate their distress, wanting the opportunity to self-manage first, not wanting to take psychotropic medications, lack of time, financial expenditure, location and proximity of services, transportation issues, and challenges associated with
childcare [8,38,39]. Therefore, instead of using formal treatments, women are more inclined to seek
the informal support of friends and family, printed material, or computer/web-based intervention
programs [7,8,40].

In a recent systematic review (2018) looking at the efficacy of IPT in perinatal women, 28
studies endorsed the effectiveness of IPT in the prevention and/or treatment of perinatal distress [41].
However, the review lacked adherence to systematic literature review best practices as the search
was limited to two databases, screening was completed by only one reviewer, and the search strategy
included limited keywords, did not include variations of terms as hyphenated terms (e.g., peri-natal),
and did not include subject headings [41]. As such, clinicians, researchers, and decisionmakers would
benefit from a systematic, comprehensive, and transparent approach to examining the use of IPT in
perinatal women.

The goal of the current systematic review was to synthesize the current literature, evaluating the
effectiveness, feasibility, and acceptability of IPT interventions to treat perinatal psychological distress.
The question guiding this systematic review was: What is the effectiveness of IPT for women during
the perinatal period on the reduction of stress, anxiety, and depression and improvement in quality of
life, relationship satisfaction/quality, social support, and psychological wellbeing?

2. Methods

2.1. Protocol and Registration

The protocol for this systematic review was developed based on the Preferred Reporting Items
for Systematic reviews and Meta-analyses Protocols (PRISMA-P) [42] and has been registered with
PROSPERO CRD42019114292. The systematic literature protocol paper has also been published
(K. S. Bright et al., 2019) [43].

2.2. Eligibility Criteria

The studies selected for inclusion in this systematic review met the following eligibility criteria,
which are described according to participants, study design (including publication, language, and year),
intervention, and outcomes.

2.3. Participants

Perinatal women from conception to 12 months postpartum who participated in an IPT intervention
were included. For this systematic review, we excluded women who were not pregnant or postpartum.

2.4. Study Design

The review considered studies evaluating the feasibility, acceptability, effectiveness, and/or
efficacy of IPT in perinatal women. Experimental studies such as randomized controlled/clinical trials
(RCTs), quasi-experimental studies, as well as single group pre-post studies were included in the
review. Observational studies, including cohort and case control studies, were included. We included
qualitative studies that explored the acceptability of IPT interventions. We excluded conference papers,
dissertations, reviews, and non-English publications.

2.5. Interventions

We defined IPT intervention as interpersonal therapy, or any intervention, counseling,
psychotherapy, therapy, or program where there was a component of IPT offered. IPT included
those interventions targeted towards women during the perinatal period.

2.6. Comparator

We included studies with all types of comparator groups, such as pre-post interventions,
non-exposed control group, or a group exposed to a different intervention.
2.7. Information Sources and Search Strategy

MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily (Ovid), EMBASE (Ovid), PsycINFO (Ovid), Cochrane Central Register of Controlled Trials (OVID), CINAHL with Full Text (Ebsco), Social Work Abstracts (Ebsco), SocINDEX with Full Text (Ebsco), Academic Search Complete (Ebsco), Family & Society Studies Worldwide (Ebsco), Family Studies Abstracts (Ebsco), and Scopus databases were searched from database inception to 31 January 2019 and rerun on 11 May 2020. (See Supplementary Materials for the Medline search strategy).

2.8. Screening of Studies

Prior to screening, the two reviewers (KSB and EMC) completed a calibration exercise where 10% of studies were reviewed independently and then together assessed for inter-rater agreement. In the calibration exercise, there was 93% agreement. Following the calibration exercise, the two reviewers independently screened the studies for eligibility in two steps. The first step consisted of reviewing all studies’ titles/abstracts to identify studies that met the eligibility criteria. The second step consisted of reviewing the provisionally included studies’ full text to ensure that they met all the inclusion criteria. Any disagreements were resolved by discussion between the two reviewers. There were 45 studies that met the inclusion criteria (Figure 1. PRISMA Diagram).

![PRISMA Diagram](image_url)

Figure 1. PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) Diagram.

2.9. Risk of Bias in Individual Studies

Studies were included regardless of methodological quality. The Effective Public Health Practice Project (EPHPP) Quality Assessment Tool was used for quality assessment. Two reviewers (KSB and
EMC) independently assessed all studies for quality and disagreements were resolved by discussion between the two reviewers.

3. Results

3.1. Characteristics of Included Studies

Characteristics of the 45 studies included in this systematic review are presented in Table 1. There were 25 (56%) RCTs, 10 (22%) quasi-experimental studies, eight (18%) open trials, and two (4%) single cases. Of these studies, 33 (73%) provided IPT as a treatment and 12 (27%) provided it for prevention. Most studies (n = 28, 62.2%) were conducted in the USA, with 11.1% (five) in China, 6.7% (three) in Australia, 4.4% (two) in Canada, 4.4% (two) in Hong Kong, 2.2% (one) in Iran, 2.2% (one) in Singapore, 2.2% (one) in Austria, 2.2% (one) in Hungary, and 2.2% (one) in Israel. Among the RCTs and quasi-experimental studies, 15 (48.6%) used comparisons of treatment as usual (TAU), 16 (37.1%) were active treatment, three (8.6%) were waitlist control (WLC), one (2.9%) was WLC and TAU, and one (2.9%) was WLC and active treatment. Of the active treatment comparison type studies, six studies used education-based programs, four studies used psychological programs/sessions, two studies used antidepressant medications, and one used mindfulness-based therapy.

Characteristics of the interventions are presented in Table 2. In most studies (n = 24, 53%), the IPT intervention was delivered individually; in 17 (38%) studies IPT was delivered in a group setting, two (4%) studies delivered the intervention as a combination of group and individual IPT, and two (4%) studies included partners in the delivery of the intervention. Most studies (n = 29, 64.4%) delivered the IPT face-to-face, while two (4.4%) studies delivered IPT over the phone and 14 (31.1%) studies combined face-to-face and telephone calls.

Most interventions were initiated during pregnancy (n = 27, 60%), with the remaining 18 (40%) studies initiated during the postpartum period. IPT was administered individually in 24 (53%) studies and in groups in 17 (38%) studies. Women’s partners were included in the intervention in two (4%) studies. Most studies (n = 30, 66.7%) provided IPT in a community setting (e.g., women’s recreation facility), 12 (26.7%) studies provided IPT in the clinical setting (e.g., prenatal clinic), and three (6.7%) studies provided IPT in a mixed clinical and community setting. The number of IPT sessions ranged from two to 16 sessions, with an average of eight sessions. Most studies (n = 35, 78%) reported provided IPT according to a study or intervention protocol.

Characteristics of the method of assessment for outcomes are presented in Table 3. In most studies (n = 28, 62.2%), depressive symptoms were assessed using the Edinburgh Postnatal Depression Scale (EPDS), while 16 (35.6%) studies used the Hamilton Depression Rating Scale (HAM-D), 16 (35.6%) used the Beck Depression Inventory (BDI), three (6.7%) studies used the CESD, and three (6.7%) studies used the SCL-20. Symptoms of anxiety were assessed in 18 (40%) studies, most commonly using the State-Trait Anxiety Inventory and Beck Anxiety Inventory. Stress levels were assessed in 10 (22%) of the studies. Maternal-infant attachment was assessed in 16 (36%) of the studies. Eleven (24%) of the studies assessed social support. Relationship satisfaction/quality was assessed in 17 (38%) of the studies.

Characteristics of study methodological quality are presented in Table 4. Methodological quality was assessed using the Effective Public Health Practice Project (EPHPP) Quality Assessment Tool [86]. The study scores ranged from 1 (strong) to 3 (weak), with an average of 2 (moderate). There were 18 studies (40%) categorized as strong overall, 14 (31%) studies were moderate overall, and 13 (29%) studies were weak overall. Study design was assessed as strong in 26 (57.8%) studies, intervention integrity was determined to be strong in 35 (78%) studies, and data analysis was assessed as strong in 20 (44%) studies.
| Study                        | Number (N) | Country  | Trial Type (OT, RCT, QRT) | Study Type (Prevention or Treatment) | Comparison Type (Active, Treatment as Usual, Waitlist Control) | Comparison Treatment                                      | Sample Population (Community, Clinical, Mixed, Prenatal, Postpartum) | Inclusion Type (Clinical Diagnosis, Self-Reported, Selected/Indicated, Universal) | Effectiveness of Treatment on Psychological Wellbeing |
|-----------------------------|------------|----------|---------------------------|---------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------|
| Bhat et al. (2017) [44]     | 160        | USA      | RCT                       | Treatment                             | Treatment as usual (Maternity support services (MSS) Plus)       | Community, Prenatal                                        | Selected/Indicated                                                   | Yes—depressive symptoms                                                  |
| Bowen, Baetz, Schwartz,     | 106        | Canada   | QRT                       | Prevention                            | Active Mindfulness-Based Therapy (MBT)                          | Community, Prenatal                                        | Universal                                                      | Yes—depressive symptoms and stress                                       |
| Balbuena, and Muhajarine    |            |          |                           |                                       |                                                                  |                                                            |                                                               |                                                                           |
| (2014) [45]                 |            |          |                           |                                       |                                                                  |                                                            |                                                               |                                                                           |
| Brandon et al. (2012) [21]  | 11         | USA      | OT                        | Treatment                             |                                                                  | Clinical, Mixed Prenatal and Postpartum                    | Clinical diagnosis                                               | Yes—depressive symptoms                                                  |
| Chen (2011) [46]            | 176        | Singapore| QRT                       | Treatment                             | Psychological, occupational, and/or medical social worker      | Clinical, Postpartum                                      | Self-reported                                                   |                                                                           |
| Community resources program |            |          |                           |                                       |                                                                  |                                                            |                                                               |                                                                           |
| Chung (2015) [47]           | 1          | Hong Kong| Single Case Design        | Treatment                             |                                                                  | Clinical, Postpartum                                      | Clinical diagnosis                                               | Yes—depression and anxiety symptoms                                     |
| Clark, Thuczek, and Wenzel  | 66         | USA      | QRT                       | Treatment                             | Active, Waitlist Control                                       | Clinical, Postpartum                                      | Universal                                                      | Yes—depressive symptoms and stress                                       |
| (2003) [48]                 |            |          |                           |                                       |                                                                  |                                                            |                                                               |                                                                           |
| Crockett, Zlotnick, Davis,  | 36         | USA      | RCT                       | Prevention                            | Treatment as usual                                              | Community, Prenatal                                        | Selected/Indicated                                               |                                                                           |
| Payne, and Washington       |            |          |                           |                                       |                                                                  |                                                            |                                                               |                                                                           |
| (2008) [49]                 |            |          |                           |                                       |                                                                  |                                                            |                                                               |                                                                           |
| Study                                      | Number (N) | Country | Trial Type (OT, RCT, QRT) | Study Type (Prevention or Treatment) | Comparison Type (Active, Treatment as Usual, Waitlist Control) | Comparison Treatment | Sample Population (Community, Clinical, Mixed, Prenatal, Postpartum) | Inclusion Type (Clinical Diagnosis, Self-Reported, Selected/Indicated, Universal) | Effectiveness of Treatment on Psychological Wellbeing |
|-------------------------------------------|------------|---------|---------------------------|-------------------------------------|-------------------------------------------------------------------|----------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------||
| Deans, Reay, and Buist (2016) [50]        | 1          | AUS     | Single Case Design        | Treatment                           | Treatment as usual                                                 | Community, Postpartum | Clinical diagnosis                                                   |                                                                                  |                                                |
| Dennis, Grigoriadis, Zupancic, Kiss, and Ravitz (2020) [51] | 241        | Canada  | RCT                       | Treatment                           | Treatment as usual (Standard postpartum depression services)       | Community, Postpartum | Selected/Indicated                                                   |                                                                                  |                                                |
| Field et al. (2009) [52]                   | 112        | USA     | QRT                       | Treatment                           | Active                                                            | Community, Prenatal  | Clinical diagnosis                                                   | Yes—depression, anxiety, and stress                                            |                                                |
| Field, Diego, Delgado, and Medina (2013) [53] | 44         | USA     | RCT                       | Treatment                           | Active                                                            | Community, Postpartum | Clinical diagnosis                                                   | Yes—depression, anxiety, and stress                                            |                                                |
| Forman et al. (2007) [54]                  | 176        | USA     | RCT                       | Treatment                           | Waitlist Control (depressed mothers) and Comparison Group (non-depressed mothers) | Community, Postpartum | Clinical diagnosis                                                   | Yes—depressive symptoms                                                          |                                                |
| Study                                      | Number (N) | Country | Trial Type (OT, RCT, QRT) | Study Type (Prevention or Treatment) | Comparison Type (Active, Treatment as Usual, Waitlist Control) | Comparison Treatment | Sample Population (Community, Clinical, Mixed, Prenatal, Postpartum) | Inclusion Type (Clinical Diagnosis, Self-Reported, Selected/Indicated, Universal) | Effectiveness of Treatment on Psychological Wellbeing |
|-------------------------------------------|------------|---------|---------------------------|-------------------------------------|---------------------------------------------------------------|----------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------|
| L. L. Gao, Chan, Li, Chen, & Hao (2010) [55] | 194        | China   | RCT                       | Prevention                          | Active                                                        | Childbirth education program only (routine antenatal education, consisting of 2 × 90-min sessions conducted by midwives, content: delivery process and childcare) | Community, Prenatal                           | Universal                                        | Yes—depressive symptoms                           |
| L. L. Gao, Chan, & Sun, 2012 [56]         | 194        | China   | RCT                       | Prevention                          | Active                                                        | Childbirth education program only (routine antenatal education, consisting of 2 × 90-min sessions conducted by midwives, content: delivery process and childcare) | Community, Prenatal                           | Universal                                        | Yes—depressive symptoms                           |
| L. L. Gao, Luo, and Chan (2012) [57]       | 83         | China   | OT                        | Prevention                          |                                                              |                                                                  | Community, Postpartum                             | Universal                                        |                                                                                             |
| L. L. Gao, Sun, and Chan (2014) [58]       | 68         | China   | QRT                       | Prevention                          | Active                                                        | Childbirth education program only (routine antenatal education, consisting of 2 × 90-min sessions conducted by midwives, content: delivery process and childcare) | Community, Prenatal                           | Universal                                        |                                                                                             |
| L. L. Gao, Xie, Yang, and Chan (2015) [59] | 180        | China   | RCT                       | Prevention                          | Treatment as usual (TAU) (pamphlet on sources of assistance after discharge) |                                                                  | Community, Postpartum                             | Universal                                        | Yes—depressive symptoms                           |
### Table 1. Cont.

| Study                                      | Number (N) | Country | Trial Type (OT, RCT, QRT) | Study Type (Prevention or Treatment) | Comparison Type (Active, Treatment as Usual, Waitlist Control) | Comparison Treatment | Sample Population (Community, Clinical, Mixed, Prenatal, Postpartum) | Inclusion Type (Clinical Diagnosis, Self-Reported, Selected/Indicated, Universal) | Effectiveness of Treatment on Psychological Wellbeing |
|--------------------------------------------|------------|---------|---------------------------|-------------------------------------|----------------------------------------------------------------|--------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Grote, Bledsoe, Swartz, and Frank (2004)   | 12         | USA     | OT                        | Treatment                           |                                                                  |                    | Community, Prenatal (pregnant, depressed, socioeconomically disadvantaged) | Self-reported                                                                     | Yes—depression and anxiety symptoms                                                |
| Grote et al. (2009) [61]                   | 53         | USA     | RCT                       | Treatment                           | Treatment as usual                                                  | Enhanced Usual Care | Community, Prenatal (pregnant, depressed, socioeconomically disadvantaged) | Self-reported                                                                     | Yes—depressive symptoms                                                            |
| Grote et al. (2015) [62]                   | 164        | USA     | RCT                       | Treatment                           | Active                                                            | Intensive Maternity Support Services (MSS-Plus)               | Community, Prenatal (pregnant, depressed, socioeconomically disadvantaged)     | Self-reported                                                                     | Yes—depression and anxiety symptoms                                                |
| Grote et al. (2017) [63]                   | 164        | USA     | RCT                       | Treatment                           | Active                                                            | Intensive Maternity Support Services (MSS-Plus)               | Community, Prenatal (pregnant, depressed, socioeconomically disadvantaged)     | Self-reported                                                                     | Yes—depressive symptoms                                                            |
| Hajiheidari, Sharifi, and Khorvash (2013)  | 34         | Iran    | QRT                       | Treatment                           | Treatment as usual                                                  | Referred to Mental health providers                        | Community, Postpartum                                                         | Clinical diagnosis                                                                | Yes—depressive symptoms                                                            |
| Study | Number (N) | Country | Trial Type (OT, RCT, QRT) | Study Type (Active, Treatment as Usual, Waitlist Control) | Comparison Treatment Type (Active, Treatment as Usual, Waitlist Control) | Sample Population (Community, Clinical, Mixed, Prenatal, Postpartum) | Inclusion Type (Clinical Diagnosis, Self-Reported, Selected/Indicated, Universal) | Effectiveness of Treatment on Psychological Wellbeing |
|-------|------------|---------|--------------------------|----------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| Kao, Johnson, Todorova, and Zlotnick (2015) [65] | 99 | USA | RCT | Treatment | Treatment as usual | Community, Prenatal | Selected/Indicated |  |
| Klier, Muzik, Rosenblum, and Lenz (2001) [66] | 17 | Austria | OT | Treatment | Treatment as usual | Clinical, Postpartum | Clinical diagnosis | Yes—depressive symptoms |
| Kozinszky, Dudas, Devosa, Csatorda, Tóth, et al. (2012) [67] | 1719 | Hungary | RCT | Prevention | Treatment as usual | Community, Prenatal | Universal | Yes—depressive symptoms |
| Lenze, Rodgers, and Luby (2015) [68] | 9 | USA | OT | Treatment | Treatment as usual | Community, Prenatal | Clinical diagnosis | Yes—depressive symptoms |
| Lenze and Potts (2017) [69] | 42 | USA | RCT | Treatment | Treatment as usual | Community, Prenatal | Clinical diagnosis | Yes—depressive and anxiety symptoms |
| Leung and Lam (2012) [70] | 156 | Hong Kong | RCT | Prevention | Treatment as usual | Community, Prenatal | Universal | Yes—stress |
| Study                                      | Number (N) | Country  | Trial Type (OT, RCT, QRT) | Study Type (Prevention or Treatment) | Comparison Type (Active, Treatment as Usual, Waitlist Control) | Comparison Treatment | Sample Population (Community, Clinical, Mixed, Prenatal, Postpartum) | Inclusion Type (Clinical Diagnosis, Self-Reported, Selected/Indicated, Universal) | Effectiveness of Treatment on Psychological Wellbeing |
|-------------------------------------------|------------|----------|---------------------------|-------------------------------------|---------------------------------------------------------------|----------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------|
| Moel, Buttner, O’Hara, Stuart, and Gorman (2010) [71] | 176        | USA      | RCT                       | Treatment                           | Waitlist control and Treatment as usual                       | Treatment as usual (TAU) (no depression, no intervention), Waitlist control (no intervention during 12 week wait, then received 12-week IPT) | Community, Postpartum                                                           | Selected/Indicated                                                                         | Yes—depressive symptoms                                             |
| Mulcahy, Reay, Wilkinson, and Owen (2010) [72]        | 57         | Australia | RCT                       | Treatment                           | Treatment as usual                                            | Encompassed all options for postnatal depression that were available to women in the Australian Capital Territory (ACT) community, such as antidepressant, natural remedies, nondirective counselling, maternal and child health nurse support, community support groups, individual psychotherapy or group therapy already provided in the community (either publicly or privately) | Clinical, Postpartum                                                      | Clinical diagnosis                                                                         | Yes—depressive symptoms                                             |
| Nylen et al. (2010) [73]                         | 120        | USA      | QRT                       | Treatment                           | Waitlist control                                              | Waitlist control (WLC) (after 12 week waiting period, Waitlist control received 12 IPT sessions) | Community, Postpartum                                                      | Selected/Indicated                                                                         | Yes—depressive symptoms                                             |
| Study                                      | Number (N) | Country | Trial Type (OT, RCT, QRT) | Study Type (Prevention or Treatment) | Comparison Type (Active, Treatment as Usual, Waitlist Control) | Comparison Treatment                                                                                      | Sample Population (Community, Clinical, Mixed, Prenatal, Postpartum) | Inclusion Type (Clinical Diagnosis, Self-Reported, Selected/Indicated, Universal) | Effectiveness of Treatment on Psychological Wellbeing |
|-------------------------------------------|------------|---------|---------------------------|-------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------|
| O’Hara, Stuart, Gorman, and Wenzel (2000) [74] | 120        | USA     | QRT                       | Treatment                           | Waitlist control (WLC) (after 12 week waiting period, Waitlist control received 12 IPT sessions) | Clinical, Postpartum                                                                                      | Clinical, Postpartum                                                                 | Clinical diagnosis                                                                 | Yes—depressive symptoms                                      |
| O’Hara et al. (2019) [75]                  | 53         | USA     | RCT                       | Treatment                           | Active                                                          | IPT (n = 56), Sertraline (n = 56), clinical management and pill placebo (n = 53)                          | Clinical, Postpartum                                                                                     | Clinical diagnosis                                                                 |                                                             |
| Pearlstein et al. (2006) [76]              | 23         | USA     | QRT                       | Treatment                           | Active                                                          | Sertraline (n = 2), Sertraline and IPT (n = 10)—Sertraline component: 8 sessions over 12 weeks           | Clinical, Postpartum                                                                                     | Clinical diagnosis                                                                 | Yes—depressive symptoms                                      |
| Posmontier, Neugebauer, Stuart, Chittams, and Shaughnessy (2016) [77] | 61         | USA     | QRT                       | Treatment                           | Active                                                          | Referral to a variety of Mental Health Practitioner (MHP) who provided various psychotherapeutic modalities such as supportive and psychodynamic psychotherapy | Clinical, Postpartum                                                                                     | Clinical diagnosis                                                                 | Yes—depressive symptoms                                      |
| Posmontier et al. (2019) [78]              | 27         | Israel  | OT                        | Treatment                           | Active                                                          | Includes a variety of cognitive-behavioral, psychodynamic, psychoeducational, and/or non-specific supportive modalities, varying number, and duration of sessions | Clinical, Postpartum                                                                                     | Clinical diagnosis                                                                 | Yes—depressive symptoms                                      |
| Study                                      | Number (N) | Country   | Trial Type (OT, RCT, QRT) | Study Type (Prevention or Treatment) | Comparison Type (Active, Treatment as Usual, Waitlist Control) | Comparison Treatment | Sample Population (Community, Clinical, Mixed, Prenatal, Postpartum) | Inclusion Type (Clinical Diagnosis, Self-Reported, Selected/Indicated, Universal) | Effectiveness of Treatment on Psychological Wellbeing |
|-------------------------------------------|------------|-----------|--------------------------|-------------------------------------|---------------------------------------------------------------|----------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------|
| Reay et al. (2006) [79]                   | 18         | Australia | OT                       | Treatment                           |                                                               |                      | Community, Postpartum                                               | Selected/Indicated                                                               | Yes—depressive symptoms                       |
| M. G. Spinelli (1997) [19]                 | 13         | USA       | OT                       | Treatment                           |                                                               |                      | Clinical, Prenatal                                                  | Clinical diagnosis                                                                 | Yes—depressive symptoms                       |
| Spinelli and Endicott (2003) [20]         | 50         | USA       | RCT                      | Treatment                           | Active                                                        |                      | Parenting Education Program for Unipolar Depressed Nonpsychotic pregnant women (therapist-led weekly 45 min sessions for 16 weeks) | Mixed Clinical and Community, Prenatal                                              | Yes—depressive symptoms                       |
| Spinelli, Endicott, Leon, et al. (2013) [80] | 142       | USA       | RCT                      | Treatment                           | Active                                                        |                      | Parent Education Program (therapist-led 45 min weekly didactic lectures on pregnancy, postpartum, breastfeeding education—provided to 100% participants, and early infant development) | Mixed Clinical and Community, Prenatal                                              | Yes—depressive symptoms                       |
| Spinelli, Endicott, and Goetz (2013) [81] | 142       | USA       | RCT                      | Treatment                           | Active                                                        |                      | Parent Education Program (therapist-led 45 min weekly didactic lectures for 12 weeks) | Mixed Clinical and Community, Prenatal                                              | Clinical diagnosis                             |
| Zlotnick, Johnson, Miller, Pearlstein, and Howard (2001) [82] | 37         | USA       | RCT                      | Prevention                          | Treatment as Usual—standard medical attention and treatment provided to all attending prenatal clinic |                      | Community, Prenatal                                                  | Selected/Indicated                                                                        |                                                 |
| Study                                      | Number (N) | Country | Trial Type (OT, RCT, QRT) | Study Type (Prevention or Treatment) | Comparison Type (Active, Treatment as Usual, Waitlist Control) | Comparison Treatment | Sample Population (Community, Clinical, Mixed, Prenatal, Postpartum) | Inclusion Type (Clinical Diagnosis, Self-Reported, Selected/Indicated, Universal) | Effectiveness of Treatment on Psychological Wellbeing |
|-------------------------------------------|------------|---------|----------------------------|--------------------------------------|-----------------------------------------------------------------|----------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------|
| Zlotnick, Miller, Pearlstein, Howard, and Sweeney (2006) [83] | 99         | USA     | RCT                        | Prevention                           | Treatment as Usual                                              | Standard Antenatal Care                                      | Community, Prenatal                                                   | Selected/Indicated                                                                 |                                                   |
| Zlotnick, Capezza, and Parker (2011) [84] | 54         | USA     | RCT                        | Treatment                            | Treatment as Usual                                              | Treatment as usual—(standard medical attention and treatment provided to all attending prenatal clinic and educational material/listing of resources for IPV) | Community, Prenatal                                                   | Selected/Indicated                                                                 |                                                   |
| Zlotnick, Tzilos, Miller, Seifer, and Stout (2016) [85] | 205        | USA     | RCT                        | Prevention                           | Treatment as Usual                                              | Standard Antenatal Care                                      | Community, Prenatal                                                   | Selected/Indicated                                                                 |                                                   |
### Table 2. Characteristics of Interventions.

| Study                        | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention | Comments | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|------------------------------|----------------------------------|----------------------------------------|--------------|----------|----------------------------------------------------------|------------------------|---------------------------------|-----------------|--------------|
| Bhat et al. (2017) [44]       | PN                               | MSS-Plus from pregnancy to 2 months PP, MOMCare from pregnancy to 12 months PP | Pretherapy engagement brief IPT, Pharmacotherapy or both (MOMCare) | Individual | Combination Face-to-face Telephone                       | Community               | No                              | Not specified   | Not specified |
| Bowen et al. (2014) [45]      | PN                               | 15–25 weeks pregnant                   | IPT          | 6 weeks duration | Group                                                   | Face-to-face            | Community                       | No              | 5 group sessions |
| Brandon et al. (2012) [21]    | PN                               | From 12 weeks prenatal to 12 weeks postpartum | 1st phase—Partner assisted IPT (both partners involved, assessed depressive experience, identify and understand the triggers of depressive symptoms), 2nd phase—Role expectations (self/and partner) and quality of their interactions, 3rd phase—consolidate change, explore sources of support, and process the experience of therapy |
|                              |                                  | | Emotional Focused Couples Therapy (EFCT) informed—Partner-Assisted IPT | Partners | Face-to-face | Clinical | Yes | 8 session to be completed within a 12-week period |
| Study | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention | Comments | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|-------|---------------------------------|----------------------------------------|--------------|----------|--------------------------------------------------------|------------------------|-------------------------------|-----------------|-------------|
| Chen (2011) [46] | PP | 2 weeks to 6 months postpartum | Principles of IPT and CBT | Individual, offered group support | Combination Face-to-face, telephone (high scorers who refused psychiatric intervention) | Clinical | No | Unsure of number of sessions, duration of treatment between 3–6 months |
| Chung (2015) [47] | PP | Unsure | IPT | Maintenance sessions—every 2 weeks for 20 min | Individual | Face-to-face | Clinical | No | 12 |
| Clark et al. (2003) [48] | PP | 4–96 weeks postpartum | IPT | Three groups—IPT (Individual), M-ITG (Group, includes elements of IPT/CBT), and WLC | Individual and Group | Face-to-face | Clinical | No | M-ITG and IPT sessions: 12 (weekly for 1 h) in addition to a 1.5-h initial intake; WLC: waiting to receive M-ITG |
| Crockett et al. (2008) [49] | PN | 24–31 weeks pregnant | ROSE Program (Reach Out, Stand Strong: Essentials for New Moms)—IPT based | Group (and Individual booster) | Face-to-face | Community (group sessions), Participant’s home (booster session) | No | 4 (1.5 h during pregnancy) group sessions weekly and 1 (50 min) individual booster 2 weeks after delivery |
| Study                  | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention                           | Comments                                                                 | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|-----------------------|---------------------------------|----------------------------------------|----------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------|------------------------|---------------------------------|------------------|---------------|
| Deans et al. (2016) [50] | PP                              | 7 months postpartum                    | IPT for the mother-child relationship | Was a group intervention—reporting on one individual in the group         | Group and Individual                                       | Face-to-face           | Community                       | Yes—1 session with partner at the halfway point (between session 5 and 6) | 10 (in addition: two pre-group individual sessions and one psychoeducation partner session at the halfway point) |
| Dennis et al. (2020) [51] | PP                              | Between 2 and 24 weeks postpartum      | IPT                                    |                                                                            | Individual                                                | Telephone              | Community                       | No               | 12 weekly 60-min telephone IPT sessions |
| Field et al. (2009) [52]  | PN                              | 22–28 weeks pregnant                   | IPT and IPT with Massage               |                                                                            | Group                                                     | Face-to-face           | Community                       | No               | Group IPT—1 hr per week for 6 weeks, IPT and Massage—1 hr IPT per week for 6 weeks, 20-min massage once a week for 6 weeks |
| Field et al. (2013) [53]  | PN                              | 22–34 weeks pregnant                   | Group IPT                              |                                                                            | Group                                                     | Face-to-face           | Community                       | No               | IPT Group: 1 h per week for 12 weeks, Peer Support Group: 20 min/week for 12 weeks |
| Forman et al. (2007) [54] | PP                              | 6 months postpartum                    | IPT with mothers and their babies      |                                                                            | Mother-infant                                             | Face-to-face           | Community                       | No               | 12 weeks of IPT |
| Study                     | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention                                                                 | Comments                                                                 | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|--------------------------|---------------------------------|----------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------|-----------------------------|-----------------|----------------|
| L. L. Gao et al., 2010 [55] | PN                              | over 28 weeks pregnant                | Routine antenatal education & IPT-oriented childbirth education program       | Small groups of no more than 10 people                                   | Groups, Telephone                                                   | Combination           | Community                   | No              |                |
|                          |                                 |                                        |                                                                              |                                                                           |                                                                     | Face-to-face (group) and one telephone follow-up call in the postpartum period (2 weeks) |                |                | Intervention group received routine antenatal education [2 × 90-min sessions conducted by midwives, content: delivery process and childcare] & IPT-oriented childbirth psychoeducation program [Two 2-hr group sessions with one telephone follow-up in the postpartum period] |

| L. L. Gao et al. (2012) [56] | PN                              | over 28 weeks pregnant                | Routine childbirth education program & IPT-oriented childbirth education program | Small groups of no more than 10 people                                   | Groups, Telephone                                                   | Combination           | Community                   | No              |                |
|                          |                                 |                                        |                                                                              |                                                                           |                                                                     | Face-to-face (group) and one telephone follow-up call in the postpartum period (2 weeks) |                |                | Intervention group received routine antenatal education [2 × 90 min sessions conducted by midwives, content: delivery process and childcare] & IPT-oriented childbirth psychoeducation program [Two 90 min antenatal group sessions with one telephone follow-up within 2 weeks after delivery] |
| Study                  | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention                                                                 | Comments                                                                                       | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|-----------------------|---------------------------------|----------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------|------------------------------|------------------|--------------|
| L. L. Gao et al. (2012) [57] | PN                             | over 28 weeks pregnant                | Routine antenatal childbirth education & IPT-oriented childbirth psychoeducation program | Small groups of no more than 10 people                                                              | Groups, Telephone                                     | Combination Face-to-face, telephone | Community                   | No               | Routine childbirth education classes (2–90-min sessions) & IPT-oriented childbirth psychoeducation program (Two 90 min antenatal group sessions with one telephone follow up within 2 weeks after delivery) |
| L. L. Gao et al. (2014) [58] | PN                             | over 28 weeks pregnant                | Routine childbirth education program & IPT-oriented childbirth education program | Groups, Telephone                                                                                 | Combination Face-to-face (group) and one telephone follow-up call in the postpartum period (2 weeks) | Community                   | No                           | Intervention group received routine antenatal education [2 × 90 min sessions conducted by midwives, content: delivery process and childcare] & IPT-oriented childbirth psychoeducation program [Two 90 min antenatal group sessions with one telephone follow up within 2 weeks after delivery] |
| Study | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention | Comments | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|-------|-------------------------------|---------------------------------------|--------------|----------|---------------------------------------------------------|------------------------|-------------------------------|-----------------|--------------|
| L. L. Gao et al. (2015) [59] | PP                            | 2–3 days postpartum                   | Pamphlet on sources of assistance after discharge & IPT-oriented postnatal psychoeducation programme | Outcomes measured: Postpartum depressive symptoms, social support, and maternal role competence | Individual | Combination Face-to-face, telephone | Community | No | One 1-hr session (before hospital discharge) and a telephone follow-up within 2 weeks after discharge |
| Grote et al. (2004) [60] | PN                            | 12–28 weeks pregnant                 | IPT-B (brief) & IPT-M (maintenance) | 12 people who screened > 10 on the EPDS, IPT sessions scheduled as much as possible preceding or following their antenatal appt, depressed, low-income, minority women | Individual | Combination Face-to-face, telephone | Community | No | 9 sessions (no timeframe for each session) (Pre-treatment engagement interview, 8 IPT-B [brief] sessions, IPT-M [maintenance] sessions monthly up to 6 months [max: 6 sessions] Postpartum) |
| Study                  | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention                                                                 | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|-----------------------|---------------------------------|---------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------|------------------------|-------------------------------|-----------------|--------------|
| Grote et al. (2009) [61] | PN                              | 10–32 weeks pregnant                  | IPT-B—multicomponent, enhanced, culturally relevant (reflected 7/8 components delineated in the culturally centered framework of Bernal and colleagues (1995)) | Individual                                        | Combination—Face-to-face, telephone | Community                     | No              | Pre-treatment engagement interview, 8—Brief IPT sessions (in-person, telephone), and bi-weekly or monthly IPT maintenance for up to 6 months post-baseline, |
| Grote et al. (2015) [62] | PN                              | 12–32 weeks pregnant                  | MSS-Plus AND MOMCare—18 month collaborative care intervention stepped treatment approach (included initial pre-treatment engagement session, choice of IPT-B and/or pharmacotherapy, telephone plus in-person visits) | Individual                                        | Combination—Face-to-face, telephone (calls or texts) | Community (Public Health Centers, Patient’s home) | No              | Pre-treatment engagement interview, 8—Brief IPT sessions every 1–2 weeks (in-person, telephone) across 3–6 months post-baseline, and monthly IPT maintenance for up to 18 months post-baseline, 60 min/session |
Table 2. Cont.

| Study                          | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention                                                                 | Comments                                                                                       | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|-------------------------------|----------------------------------|----------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------|------------------------------|-------------------|----------------|
| Grote et al. (2017) [63]      | PN                               | 12–32 weeks pregnant                   | MOMCare—18-month collaborative care intervention, stepped treatment approach—women with less than 50% improvement in depressive symptoms by 6–8 weeks received a revised treatment plan screened for depression, Patient Health Questionnaire-9 (PHQ-9) scoring ≥ 10, and screened for dysthymia: MINI | Individual                                                                                      | Combination—Face-to-face, telephone | Community (Public Health Centers, Patient’s home) | No                           | Pre-treatment engagement interview, 8—Brief IPT sessions every 1–2 weeks (in-person, telephone) across 3–4 months post-baseline, and monthly IPT maintenance for up to 18 months post-baseline, 60 min/session |
| Hajiheidari et al. (2013) [64] | PP                               | not specified                         | IPT—marriage                                                                   | EPDS ≥ 14, and by the diagnosing review by a psychologist Partners | Face-to-face | Community                          | Yes (scores not collected/analysed) | 10—sessions/10 weeks |
| Kao et al. (2015) [65]        | PN                               | 20–35 weeks pregnant                  | IPT—Reach Out, Stand Strong, Essentials for new mothers (ROSE) & standard care score of 27 or greater on a 17-item tool to assess PDD, low income | Group (3–5 people per group)                                                                 | Face-to-face | Community (Groups at prenatal clinic, Booster at clinic or participant’s home) | No                           | 4 sessions/60 min/4 weeks and one 50-min booster after delivery |
| Klier et al. (2001) [66]      | PP                               | 4–45 weeks postpartum                 | IPT                                                                           | Combination (Individual and Group)                                                              | Face-to-face | Clinical                           | No                           | 12 sessions: Individual (two 60-min pre-sessions), Group (nine 90-min weekly group sessions), Individual (one 60-min termination session) |
| Study                                      | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention                                                                 | Comments                                                                 | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|-------------------------------------------|---------------------------------|---------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------|---------------------------------|-----------------|-----------------|
| Kozinszky, Dudas, Devosai, Csatordai, Tóth, et al. (2012) [67] | PN                              | 25–29 weeks pregnant                  | Psychoeducation and psychotherapy for PPD utilizing IPT and CBT elements—each session ended with relaxation exercises | Group (max 15 per group)                                                | Face-to-face            | Community                          | Yes—allowed to attend 4 sessions—3-h—over 4 consecutive weeks |
| Lenze et al. (2015) [68]                  | PN                              | 12–30 weeks pregnant                  | IPT-Dyad—two phases, antepartum phase based on brief, culturally relevant IPT developed by Grote 2008 (weekly sessions), postpartum phase (biweekly sessions then monthly) | Individual                                                              | Face-to-face            | Community                          | No                                    | Antenatal—minimum dose 7 sessions—55% achieved minimum dose—sessions included an engagement session to explore views about depression, treatment, and barriers to care strategies of standard IPT. Postpartum—minimum dose of 8—71% achieved minimum dose—sessions were on maintaining interpersonal functioning, infant emotional development theory, and attachment theory. |
| Study                        | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention                      | Comments                                                                 | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|------------------------------|---------------------------------|----------------------------------------|-----------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------|------------------------|---------------------------------|-----------------|----------------|
| Lenze and Potts (2017) [69]  | PN                              | 12–30 weeks pregnant                   | Brief IPT engagement session and then 8 IPT sessions—those who completed all 9 sessions had access to maintenance sessions | Individual                                                  | Combination Face-to-face (participants had the option to receive brief-IPT over the phone) | Community (Sessions offered at participant’s home, at the research clinic, or at other convenient community location) | No                | 1 engagement session, 8 IPT sessions as described by Grote et al. 2004 (length of time for sessions not included) |                |
| Leung and Lam (2012) [70]    | PN                              | 14–32 weeks pregnant                   | IPT-oriented intervention         | Group                                                                 | Face-to-face                                             | Community              | No                | 4 weekly 1.5-h sessions/4 weeks |                |
| Moel et al. (2010) [71]      | PP                              | Postpartum—not sure of timing          | IPT                               | Sample from O’Hara study 2000                                           | Individual                                               | Face-to-face            | Community (Therapist’s private practice clinics) | No              | 12 h over 12 weeks |
| Mulcahy et al. (2010) [72]   | PP                              | less than 12 months postpartum         | IPT                               | 60% onset of current depression after the birth of the baby, 22% during pregnancy, 18% prior to conception | Combination (Individual, Group, partners)                | Face-to-face            | Clinical (evening session only) | Yes             | 11 sessions in total (2 individual, 8 group, 1 evening group for men only—each 2 h/session) over 8 weeks |                |
| Nylen et al. (2010) [73]     | PP                              | 6–24 months postpartum                 | IPT                               | Sample from O’Hara study 2000                                           | Individual                                               | Face-to-face            | Community              | No              | 12 h over 12 weeks (12—1-h sessions over 12 weeks) |
| O’Hara et al. (2000) [74]    | PP                              | 6–9 months postpartum                  | IPT                               | This sample also used in the Nylen study                                  | Individual                                               | Face-to-face            | Clinical              | No              | 12 h over 12 weeks |

Table 2. Cont.
| Study                          | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention       | Comments                                                                 | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|-------------------------------|---------------------------------|----------------------------------------|-------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|------------------------|-------------------------------|------------------|---------------|
| O’Hara et al. (2019) [75]     | PP                              | within 6 months postpartum             | IPT               | Recruited from 2008 to 2013                                              | Individual                                                | Face-to-face           | Clinical                      | No               | 12 individual 50-min sessions over 12 weeks |
| Pearlstein et al. (2006) [76] | PP                              | 6 months postpartum                    | IPT               | 11 women picked IPT, 2 picked sertraline, and 10 picked sertraline and IPT | Individual                                                | Face-to-face           | Clinical (outpatient mental health setting) | No               | IPT: 12–50-min sessions over 12 weeks |
| Posmontier et al. (2016) [77] | PP                              | 6 weeks–6 months postpartum           | CNM-IPT (Certified Nurse-Midwives Telephone Administered Interpersonal Psychotherapy) | Individual                                                | Telephone                        | Clinical                      | No               | 8 sessions lasting 50 min per session over a 12-week period |
| Posmontier et al. (2019) [78] | PP                              | 1–6 months postpartum                 | IPT               | Individual                                                | Individual                                                | Face-to-face           | Clinical                      | No               | Up to 8 × 50-min sessions |
| Reay et al. (2006) [79]       | PP                              | less than 12 months postpartum        | IPT-G (Group)     | Group (with individual, partners)                                      | Face-to-face                        | Community (local community centers) | Yes              | 2 individual sessions (pre-therapy, 6-week post-group appointment), 8 weekly group sessions at 2 h a session (delivered over 8 weeks), 2-h partners evening (midway through group sessions—weeks 3–7) |
| Study                          | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention                                      | Comments                                                                 | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|-------------------------------|---------------------------------|----------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------|-----------------------|---------------------------------|------------------|------------------|
| M. G. Spinelli (1997) [19]    | PN                              | 6–40 weeks pregnant                    | IPT for antenatal depression                    | lower socioeconomic 50 started—25 in each group—ended with 17 in control group and 21 in treatment group | Individual                                               | Face-to-face          | Clinical                       | No               | 16 weekly sessions, 50 min per session |
| Spinelli and Endicott (2003) [20] | PN                              | 6–36 weeks pregnant                    | IPT for antenatal depression—bilingual (Spanish and English) | Individual                                                            | Combination Face-to-face, telephone (as needed)         | Clinical and Community | No                | 16 weekly 45 min per session |
| Spinelli, Endicott, Leon, et al. (2013) [80] | PN                              | 12–33 weeks pregnant                   | IPT for antenatal depression (bilingual) (breastfeeding education provided to 83% participants even though not mandatory) | Same sample as the Spinelli et al. 2013b                               | Individual                                               | Combination Face-to-face, telephone (as needed) | Clinical and Community | No               | 12 weekly sessions—45 min per session |
| Spinelli, Endicott, and Goetz (2013) [81] | PN                              | 12–33 weeks pregnant                   | IPT for antenatal depression—bilingual (Spanish and English) | Individual                                                            | Combination Face-to-face, telephone (as needed),         | Clinical and Community | No                | 12 weekly sessions—5 min per session |
| Zlotnick et al. (2001) [82]   | PN                              | 12–32 weeks pregnant                   | IPT (Survival Skills for New Moms)              | women receiving public assistance                                     | Group                                                   | Face-to-face          | Community                       | No               | 4–60-min sessions over 4 weeks |
| Zlotnick et al. (2006) [83]   | PN                              | 12–32 weeks pregnant                   | ROSE program IPT-based intervention & standard antenatal care | women receiving public assistance                                     | Group (and Individual-booster)                          | Face-to-face          | Community                       | No               | four sessions 60 min group session over 4 weeks and a 50-min individual booster session after delivery |
### Table 2. Cont.

| Study                        | Timing (Prenatal or Postpartum) | Timing in Weeks Pregnant or Postpartum | Intervention                                                                 | Comments                                                                 | Methods of Administration (Individual, Partners, Groups) | Mode of Administration | Setting (Clinical or Community) | Included Partner | # of Sessions |
|------------------------------|---------------------------------|----------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------|------------------------|---------------------------------|------------------|---------------|
| Zlotnick et al. (2011) [84]  | PN                              | 12–32 weeks pregnant                   | IPT—for Depression and PTSD                                                  | women with intimate partner violence—low-income                           | Individual                                               | Face-to-face            | Community                       | No               | 4–60-min sessions over 4 weeks, 1–60 min individual ‘booster’ session within 2 weeks of delivery |
| Zlotnick et al. (2016) [85]  | PN                              | 20–35 weeks pregnant                   | ROSE program IPT-based intervention—group & standard antenatal care          | women receiving public assistance                                           | Group (and Individual-Booster)                         | Face-to-face            | Community                       | No               | 4–90-min group sessions over a 4-week period, and a 50-min individual booster session 2 weeks after delivery |

### Table 3. Method of Assessment for Outcomes in Included Analyses.

| Study                        | Type (Prevention or Treatment Study) | Assessment of Depressive Symptoms | Prevalence of Depressive Episodes | Assessment of Symptoms of Anxiety | Stress | Attachment | Quality of Life | Relationship Satisfaction/Quality | Adjustment | Social Support | Others                      |
|------------------------------|-------------------------------------|----------------------------------|----------------------------------|---------------------------------|--------|------------|----------------|----------------------------------|------------|----------------|-----------------------------|
| Bhat et al. (2017) [44]      | Treatment                           | SCL-20                           | PHQ-9, MINI                       | PTSD-Checklist Civilian Version (PCL-C) |        |            |                | WSAS                             | WSAS       |                | PES                         |
| Bowen et al. (2014)          | Prevention                          | EPDS                             | STAI                             | CWS                             |        |            |                | MSSS                             |            |                | Satisfaction with Psychotherapy group: 1. What did you find most positive about the group? 2. What would you change in the group? |
Table 3. Cont.

| Study                        | Type (Prevention or Treatment Study) | Assessment of Depressive Symptoms | Prevalence of Depressive Episodes | Assessment of Symptoms of Anxiety | Stress | Attachment | Quality of Life | Relationship Satisfaction/Quality | Adjustment | Social Support | Others                                                                 |
|------------------------------|-------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|--------|------------|-----------------|------------------------------------|------------|----------------|------------------------------------------------------------------------|
| Brandon et al. (2012) [21]   | Treatment                           | HAM-D, EPDS, EPDS—Partner version | DSM-IV MDD, SCID-IV, HAM-D17      | DAS                               |        |            |                 |                                    |            |                |                                                                         |
| Chen (2011) [46]             | Treatment                           | EPDS                              | EPDS                              | GAF                               |        |            |                 |                                    |            |                |                                                                         |
| Chung (2015) [47]            | Treatment                           | EPDS, HAM-D                       | EPDS = 22                         | HAM-A                             |        |            |                 |                                    |            |                |                                                                         |
| Clark et al. (2003) [48]     | Treatment                           | CES-D, BDI                        | DSM-IV MDD                        | PSI                               |        |            | PCERA           |                                    |            |                | BSID                                                                   |
| Crockett et al. (2008) [49]  | Prevention                          | EPDS                              | CSQ > 27, SCID-R                  | PSI                               |        |            |                 |                                    |            |                | SAS-SR, PPAQ                                                           |
| Deans et al. (2016) [50]     | Treatment                           | BDI                               | SCID-II, EPDS, BAI, PSI           | MAI                               |        |            |                 |                                    |            |                | Infant Characteristics Questionnaire, Emotional Availability Scales (EAS) |
| Dennis et al. (2020) [51]    | Treatment                           | EPDS > 12 eligible to be referred  | SCID depression module. EPDS > 12 | STAI                              |        |            | ECR             | DAS                                |            |                | Health service utilization and costs                                  |
| Field et al. (2009) [52]     | Treatment                           | CES-D                             | SCID-I                            | STAI                              |        |            | Cortisol samples (saliva) | The relationship questionnaire | SSQ-R      |                | STAXI                                                                   |
| Field et al. (2013) [53]     | Treatment                           | CES-D                             | SCID-I                            | STAI                              |        |            | Cortisol samples (saliva) |                                    |            |                | STAXI                                                                   |
| Forman et al. (2007) [54]    | Treatment                           | IDD, HAM-D                        | IDD, SCID, HRSD                    | PSI                               |        |            | AQS             |                                    |            |                | IBQ, CBQ, Maternal Responsiveness, Child Behaviour Problems—Child Behavior Checklist/2–3 |
Table 3. Cont.

| Study               | Type (Prevention or Treatment Study) | Assessment of Depressive Symptoms | Prevalence of Depressive Episodes | Assessment of Symptoms of Anxiety | Stress | Attachment | Quality of Life | Relationship Satisfaction/Quality | Adjustment | Social Support | Others                                                                 |
|--------------------|-------------------------------------|----------------------------------|----------------------------------|-----------------------------------|--------|------------|----------------|-----------------------------------|------------|----------------|------------------------------------------------------------------------|
| L. L. Gao et al. (2010) [55] | Prevention                         | EPDS                             | EPDS ≥ 13                        |                                    |        |            |                | Satisfaction with Interpersonal Relationships Scale                   |            |                | GHQ                                                                 |
| L. L. Gao et al. (2012) [56] | Prevention                         | EPDS, GHQ                        | EPDS ≥ 13                        |                                    |        |            |                | PSSS                              | PSOC—with Efficacy (PSOC-E). GHQ |                | Qualitative interviews— looking at close ended questions of the Program Satisfaction Questionnaires |
| L. L. Gao et al. (2012) [57] | Prevention                         |                                    |                                  |                                    |        |            |                | PSSS                              | PSOC—with Efficacy (PSOC-E)      |                |                                                                 |
| L. L. Gao et al. (2014) [58] | Prevention                         |                                    |                                  |                                    |        |            |                | PSSS                              | PSOC—with Efficacy (PSOC-E)      |                |                                                                 |
| L. L. Gao et al. (2015) [59] | Prevention                         |                                    |                                  |                                    |        |            |                | PSSS                              | PSOC—with Efficacy (PSOC-E)      |                |                                                                 |
| Grote et al. (2004) [60]   | Treatment                          | EPDS, BDI, HAM-D                 | EPDS > 10, DIS                   | BAI                               |        |            |                | IIP                               | SAS, PPAQ                           | Medical Outcomes Study Social Support Survey                                |
|                           |                                     |                                  |                                  |                                    |        |            |                |                                   |                                                      | satisfaction with each social support, participants completed a 4-item treatment satisfaction survey and 5-point Likert scale on how positive they felt about their pregnancy (after each session) |
| Study                          | Type (Prevention or Treatment Study) | Assessment of Depressive Symptoms | Prevalence of Depressive Episodes | Assessment of Symptoms of Anxiety | Stress | Attachment | Quality of Life | Relationship Satisfaction/Quality | Adjustment | Social Support | Others                                                                 |
|-------------------------------|--------------------------------------|----------------------------------|----------------------------------|-----------------------------------|--------|------------|----------------|-----------------------------------|------------|----------------|------------------------------------------------------------------------|
| Grote et al. (2009) [61]      | Treatment                            | EPDS, BDI, SCID                  | EPDS ≥ 12                        | BAI                               |        |            |                | SAS, PPAQ                        |            |                | CAGE-AID, MINI                                                          |
|                               |                                      |                                  |                                  |                                   |        |            |                |                                   |            |                |                                                                         |
| Grote et al. (2015) [62]      | Treatment                            | Hopkins Symptom Checklist SCL-20 |                                  |                                   |        |            |                |                                   |            |                | CAGE-AID, MINI, Childhood Trauma Questionnaire                          |
|                               |                                      |                                  |                                  |                                   |        |            |                |                                   |            |                |                                                                         |
| Grote et al. (2017) [63]      | Treatment                            | SCL-20                           | PHQ-9, MINI                       | PHQ                               |        |            |                |                                   |            |                | CAGE-AID, MINI, SCL-20 (Depression-free Days (DFDs)), Costs for MOMCare intervention, CSI |
|                               |                                      |                                  |                                  |                                   |        |            |                |                                   |            |                |                                                                         |
| Hajiheidari et al. (2013) [64]| Treatment                            | EPDS, BDI-II                     | EPDS ≥ 14 (used for primary screening only) |                                   |        |            |                | Revised Double Adaptive Score (Marriage Adaptive) |            |                | EPDS ≥ 14 and by the diagnosing review by a psychologist               |
| Study | Type (Prevention or Treatment Study) | Assessment of Depressive Symptoms | Prevalence of Depressive Episodes | Assessment of Symptoms of Anxiety | Stress | Attachment | Quality of Life | Relationship Satisfaction/Quality | Adjustment | Social Support | Others |
|-------|-------------------------------------|----------------------------------|---------------------------------|---------------------------------|--------|------------|----------------|-------------------------------|------------|---------------|--------|
| Kao et al. (2015) [65] | Treatment | Predictive Index of PPD, EPDS | Predictive Index of PPD—score of 27 or higher (high-risk status) | | | | | SAS | | Breast feeding—initiation and duration |
| Klier et al. (2001) [66] | Treatment | HAM-D-21, EPDS | SCID-I, HAM-D-21 > 13. | | | | | DAS | DAS | | |
| Kozinszky, Dudas, Devosa, Csatordai, Tóth, et al. (2012) [67] | Prevention | LQ ≥ 12 | | | | | | | | Additional structured questions exploring sociodemographic, economic, and psychological risk factors |
| Lenze et al. (2015) [68] | Treatment | EPDS | EPDS > 12, SCID—Axis I | PSI | | | | SSQR | | Infant-Toddler Social and Emotional Assessment, Client Satisfaction Questionnaire (acceptability) |
| Lenze and Potts (2017) [69] | Treatment | EPDS | EPDS ≥ 10, SCID | Brief-STA | ECR-R | | | SSQR | DLC, CSQ | perceived ability to cooperate in childcare, 4-item subjective happiness scale |
| Leung and Lam (2012) [70] | Prevention | EPDS | EPDS < 12 | PSS | | | | | Relationship Efficacy Measure | | |
| Study                        | Type (Prevention or Treatment Study) | Assessment of Depressive Symptoms | Prevalence of Depressive Episodes | Assessment of Symptoms of Anxiety | Stress | Attachment | Quality of Life | Relationship Satisfaction/Quality | Adjustment | Social Support | Others                                           |
|-----------------------------|-------------------------------------|----------------------------------|-----------------------------------|----------------------------------|--------|------------|----------------|-----------------------------------|------------|---------------|-------------------------------------------------|
| Moel et al. (2010) [71]     | Treatment                           | SCID, BDI, HAM-D                 | IDD, SCID-I                       | DAS                              | DAS    |            |                | LIFE-II                           |            |               |                                                 |
| Mulcahy et al. (2010) [72]  | Treatment                           | HAM-D, EPDS, BDI                 | MCMI-III, HAM-D ≥ 14             | MAI                              | DAS    |            |                | ISEL                              |            |               |                                                 |
| Nylen et al. (2010) [73]    | Treatment                           | BDI, HAM-D                       | IDD, SCID, HAM-D scores ≥ 12     | DAS                              |        |            |                | LIFE-II                           |            |               |                                                 |
| O’Hara et al. (2000) [74]   | Treatment                           | SCID, HAM-D (≥ 12), BDI          | IDD, SCID                        | DAS                              | SAS-SR, PPAQ, DAS | HAM-D adding items on hypersomnia, hyperphagia and weight gain |
|                             |                                     |                                  |                                   |                                  |        |            |                |                                   |            |               |                                                 |
| O’Hara et al. (2019) [75]   | Treatment                           | BDI, EPDS, PHQ-9 replaced the EPDS | SCID, HAM-D ≥ 15                | Inventory of Depression and Anxiety Symptoms, General depression scale | PPAQ |            |                |                                   |            |   Clinical Global Impressions-Severity of Illness and Improvement scales |
| Pearlstein et al. (2006) [76]| Treatment                           | BDI, HAM-D, EPDS                 | SCID, BDI ≥ 25, HAM-D ≥ 14, EPDS | DAS                              |        |            |                |                                   |            |               |                                                 |
| Posmontier et al. (2016) [77]| Treatment                           | HAM-D, EPDS                      | EPDS > 9, MINI—met criteria for MDD | Mother-to-Infant Bonding Scale  | DAS    |            |                |                                   |            |               | GAF, CSQ-8, MINI, IAQS                      |
| Posmontier et al. (2019) [78]| Treatment                           | EPDS                             | EPDS score of 10–18 for inclusion | PPAQ |            |                |                                   |            |               | CSQ-8                                           |
| Reay et al. (2006) [79]     | Treatment                           | HAM-D, EPDS, BDI                 | EPDS > 13                        | SAS                              |        |            |                |                                   |            |               | Patient Satisfaction Survey (developed for this study) |
| Study                                      | Type (Prevention or Treatment Study) | Assessment of Depressive Symptoms | Prevalence of Depressive Episodes | Assessment of Symptoms of Anxiety | Stress | Attachment | Quality of Life | Relationship Satisfaction/Quality | Adjustment | Social Support | Others                                                                 |
|-------------------------------------------|--------------------------------------|----------------------------------|----------------------------------|-----------------------------------|--------|------------|----------------|-----------------------------------|------------|----------------|----------------------------------------------------------------------|
| M. G. Spinelli (1997) [19]                | Treatment                            | HAM-D, EPDS, BDI                 | SCID, HAM-D ≥ 12                 |                                   |        |            |                |                                   |            |                | Serum thyroid function tests, Clinical Global Impression (global ratings of symptom severity and improvement) |
| Spinelli and Endicott (2003) [20]         | Treatment                            | HAM-D, BDI, EPDS                 | SCID, HAM-D ≥ 12                 |                                   |        |            |                | Maudsley Mother Infant Interaction Scale |            |                | Assessment of Mood Change (weekly), Clinical Global Impression (global ratings of symptom severity and improvement) |
| Spinelli, Endicott, Leon, et al. (2013) [80] | Treatment                           | HAM-D, EPDS                      | SCID, HAM-D ≥ 12                 |                                   |        |            |                | Postpartum Bonding Questionnaire     |            |                | Breastfeeding, SCID for DSM-IV to rule out comorbid diagnosis, Clinical Global Impression (global ratings of symptom severity and improvement) |
| Spinelli, Endicott, and Goetz (2013) [81] | Treatment                           | HAM-D, EPDS                      | SCID, HAM-D ≥ 12                 |                                   |        |            |                | Maternal Fetal Attachment Scale     |            |                | SCID for DSM-IV to rule out comorbid diagnosis, Clinical Global Impression (global ratings of symptom severity and improvement) |
| Zlotnick et al. (2001) [82]               | Prevention                           | BDI                              |                                  |                                   |        |            |                |                                   |            |                | Range of Impaired Functioning Tool                                      |
| Zlotnick et al. (2006) [83]               | Prevention                           | BDI, LIFE                         | CSQ > 27                         |                                   |        |            |                |                                   |            |                | SCID for DSM-IV-NP Axis 1 to rule out comorbid diagnosis,             |
| Study | Type (Prevention or Treatment Study) | Assessment of Depressive Symptoms | Prevalence of Depressive Episodes | Assessment of Symptoms of Anxiety | Stress | Attachment | Quality of Life | Relationship Satisfaction/Quality | Adjustment | Social Support | Others |
|-------|-------------------------------------|-----------------------------------|---------------------------------|---------------------------------|--------|------------|----------------|----------------------------------|-----------|----------------|--------|
| Zlotnick et al. (2011) [84] | Prevention | EPDS, PSR, LIFE |                     |                                  |        |            |                |                                  |           |                | Revised Conflict Tactic Scale (CTS2)—assessed for IPV in last year for inclusion The Davidson Trauma Scale Criterion A from the PTSD module of the SCID-NP for DSM-IV—assessed for history of trauma, SCID-NP for DSM-IV Axis I—assessed for affective d/o, PTSD, SUD for exclusion |
| Zlotnick et al. (2016) [85] | Prevention | LIFE, PSR | CSQ > 27 |                     |        |            |                |                                  |           |                | SCID for DSM-IV-NP to exclude those with comorbid diagnosis, Treatment Services Review (TSR) |
### Table 4. Effective Public Health Practice Project (EPHPP) Quality Assessment Tool.

| Study                                      | Selection Bias | Study Design | Confounders | Blinding | Data Collection Methods | Withdrawal or Drop-Outs | Intervention Integrity | Analysis | Overall Rating |
|--------------------------------------------|----------------|--------------|-------------|----------|--------------------------|--------------------------|------------------------|----------|----------------|
| Bhat et al. (2017) [44]                  | 1              | 1            | 3           | 3        | 1                        | 2                        | 2                      | 2        | 2             |
| Bowen et al. (2014) [45]                  | 3              | 3            | 3           | 3        | 1                        | 1                        | 1                      | 2        | 3             |
| Brandon et al. (2012) [21]                | 3              | 3            | 3           | 3        | 1                        | 1                        | 1                      | 2        | 3             |
| Chen (2011) [46]                          | 2              | 3            | 3           | 3        | 1                        | 3                        | 3                      | 2        | 3             |
| Chung (2015) [47]                         | 3              | 3            | 3           | 3        | 2                        | 1                        | 1                      | 2        | 3             |
| Clark et al. (2003) [48]                  | 1              | 2            | 1           | 2        | 1                        | 2                        | 1                      | 2        | 2             |
| Crockett et al. (2008) [49]               | 1              | 1            | 2           | 2        | 1                        | 1                        | 1                      | 2        | 1             |
| Deans et al. (2016) [50]                  | 3              | 3            | 3           | 3        | 1                        | 1                        | 1                      | 2        | 3             |
| Dennis et al. (2020) [51]                 | 1              | 1            | 2           | 1        | 2                        | 1                        | 1                      | 1        | 1             |
| Field et al. (2009) [52]                  | 2              | 1            | 1           | 2        | 1                        | 1                        | 1                      | 2        | 2             |
| Field et al. (2013) [53]                  | 2              | 1            | 1           | 2        | 1                        | 1                        | 1                      | 2        | 1             |
| Forman et al. (2007) [54]                 | 2              | 1            | 1           | 1        | 1                        | 2                        | 1                      | 2        | 1             |
| L. L. Gao et al. (2010) [55]              | 1              | 1            | 1           | 2        | 1                        | 1                        | 1                      | 2        | 1             |
| L. L. Gao et al. (2012) [56]              | 1              | 1            | 2           | 1        | 1                        | 1                        | 1                      | 1        | 1             |
| L. L. Gao et al. (2012) [57]              | 3              | 3            | 3           | 3        | 2                        | 1                        | 1                      | 1        | 3             |
| L. L. Gao et al. (2014) [58]              | 3              | 3            | 2           | 3        | 2                        | 1                        | 1                      | 1        | 3             |
| L. L. Gao et al. (2015) [59]              | 1              | 1            | 1           | 2        | 1                        | 1                        | 1                      | 1        | 1             |
| Grote et al. (2004) [60]                  | 1              | 1            | 1           | 1        | 1                        | 1                        | 1                      | 1        | 1             |
| Grote et al. (2009) [61]                  | 1              | 1            | 1           | 3        | 1                        | 1                        | 1                      | 1        | 1             |
| Grote et al. (2015) [62]                  | 1              | 1            | 1           | 1        | 1                        | 1                        | 1                      | 1        | 1             |
| Grote et al. (2017) [63]                  | 1              | 1            | 1           | 1        | 1                        | 1                        | 1                      | 1        | 1             |
| Hajiheidari et al. (2013) [64]            | 3              | 1            | 3           | 3        | 1                        | 3                        | 1                      | 2        | 3             |
| Kao et al. (2015) [65]                    | 1              | 1            | 1           | 2        | 1                        | 1                        | 1                      | 1        | 1             |
| Klier et al. (2001) [66]                  | 2              | 2            | 3           | 3        | 3                        | 2                        | 3                      | 2        | 3             |
| Kozinszky, Dudas, Devosa, Csatordai, Toth, et al. (2012) [67] | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 |
| Lenze et al. (2015) [68]                  | 2              | 2            | 2           | 3        | 1                        | 1                        | 1                      | 1        | 2             |
| Lenze and Potts (2017) [69]               | 2              | 2            | 2           | 3        | 1                        | 1                        | 1                      | 1        | 2             |
| Leung and Lam (2012) [70]                 | 2              | 2            | 2           | 2        | 1                        | 1                        | 1                      | 1        | 2             |
| Moel et al. (2010) [71]                   | 1              | 1            | 2           | 2        | 1                        | 1                        | 1                      | 1        | 2             |
| Mulcahy et al. (2010) [72]                | 1              | 1            | 1           | 2        | 1                        | 1                        | 1                      | 1        | 1             |
| Nylen et al. (2010) [73]                  | 1              | 1            | 1           | 2        | 1                        | 1                        | 1                      | 1        | 1             |
| O’Hara et al. (2000) [74]                 | 1              | 1            | 1           | 2        | 1                        | 1                        | 1                      | 1        | 1             |
| O’Hara et al. (2019) [75]                 | 1              | 1            | 1           | 2        | 1                        | 1                        | 1                      | 1        | 1             |
| Study                                | Selection Bias | Study Design | Confounders | Blinding | Data Collection Methods | Withdrawal or Drop-Outs | Intervention Integrity | Analysis | Overall Rating |
|--------------------------------------|----------------|--------------|-------------|----------|-------------------------|-------------------------|------------------------|----------|-----------------|
| Pearlstein et al. (2006) [76]        | 1              | 3            | 2           | 3        | 2                       | 1                       | 2                      | 2        | 2               |
| Posmontier et al. (2016) [77]        | 2              | 2            | 2           | 2        | 2                       | 2                       | 1                      | 2        | 2               |
| Posmontier et al. (2019) [78]        | 1              | 3            | 2           | 3        | 1                       | 1                       | 1                      | 2        | 3               |
| Reay et al. (2006) [79]              | 2              | 2            | 2           | 3        | 1                       | 1                       | 1                      | 2        | 2               |
| M. G. Spinelli (1997) [19]           | 3              | 3            | 3           | 3        | 1                       | 2                       | 3                      | 2        | 3               |
| Posmontier et al. (2016) [77]        | 2              | 2            | 2           | 3        | 1                       | 1                       | 2                      | 2        | 2               |
| Spinelli and Endicott (2003) [20]    | 2              | 1            | 2           | 3        | 1                       | 1                       | 2                      | 2        | 2               |
| Spinelli, Endicott, Leon, et al.     | 1              | 1            | 1           | 3        | 1                       | 2                       | 2                      | 2        | 2               |
| Spinelli, Endicott, and Goetz (2013) [81] | 1              | 1            | 1           | 3        | 1                       | 2                       | 2                      | 2        | 2               |
| Zlotnick et al. (2001) [82]          | 3              | 2            | 1           | 3        | 1                       | 1                       | 1                      | 2        | 3               |
| Zlotnick et al. (2006) [83]          | 3              | 1            | 1           | 3        | 1                       | 1                       | 1                      | 1        | 3               |
| Zlotnick et al. (2011) [84]          | 1              | 2            | 2           | 3        | 1                       | 1                       | 1                      | 2        | 2               |
| Zlotnick et al. (2016) [85]          | 1              | 1            | 1           | 1        | 1                       | 1                       | 1                      | 1        | 1               |

1 = Strong, 2 = Moderate, and 3 = Weak.
Among the studies that reported sample demographic characteristics, maternal age ranged from 18 to 38 years old with a mean age of 30 years. The average gestational age for pregnant women ranged from six to 40 weeks, with an average of 23.7 weeks. The weeks postpartum of participants ranged from 0.5 to 96 weeks postpartum, with an average of 24.4 weeks.

3.2. Prevention Studies

Among the 13 prevention studies, 12 (92%) were delivered during pregnancy and one (8%) was delivered in the postpartum period.

3.3. Treatment Studies

Among the 33 treatment studies, 16 (48.5%) were delivered during the prenatal period and 17 (51.5%) studies were delivered in the postpartum period.

3.4. Change in Depressive Symptoms Between Treatment and Comparison Groups

Twelve prevention studies aimed to reduce the risk of depression in participants receiving IPT. Five studies [45,55,56,59,67] reported a significant reduction of depressive symptoms levels over time. These improvements were small to moderate in magnitude. No studies had large effect sizes. Reductions in depressive symptoms were also significantly larger in studies where IPT was delivered in a group format compared to individual IPT.

Thirty-two (71%) treatment studies assessed change in depressive symptoms among participants receiving IPT. Twenty-six studies reported a significant improvement in depressive symptoms over time. The improvements were determined to be in the moderate to large range. Reductions in depressive symptoms were more common in studies where the interventions were initiated in the postpartum period than in studies where interventions were initiated during pregnancy.

3.5. Change in Anxiety Symptoms Between Treatment and Comparison Groups

Seven prevention studies aiming to reduce the risk of symptom levels of anxiety addressed the change in symptoms of anxiety among participants receiving IPT. One study (Bowen et al., 2014) reported a significant reduction in the risk level of anxiety symptoms. The effect size of the intervention on symptoms of anxiety was not reported in this study.

Eleven treatment studies assessed the change in symptoms of anxiety among participants receiving IPT. Six studies [47,52,53,60,62,69] reported significant reductions in symptoms of anxiety. There was an overall reduction in symptoms of anxiety among participants receiving IPT, with an effect size in the moderate range. More studies of individual delivery showed a reduction in anxiety than group delivery. Reductions in anxiety were also noted more frequently in studies where IPT was delivered in a medical/clinical setting compared to a community setting.

3.6. Change in Stress Symptoms Between Treatment and Comparison Groups

Three prevention studies aimed at reducing the risk of stress levels assessed change in symptoms of stress among participants receiving IPT. Two studies (Bowen et al., 2014; Leung & Lam, 2012) reported a significant reduction in the risk of symptom levels of stress. One study did not report an effect size of the intervention and the other reported a very small effect size (Leung & Lam, 2012).

Seven treatment studies assessed for change in symptoms of stress among women receiving IPT. Two of these studies (Field et al., 2009; Field et al., 2013) reported a significant reduction in symptoms of stress for participants receiving IPT. The effect sizes of the intervention were not reported.
3.7. Change in Relationship Quality Between Treatment and Comparison Groups

Three prevention studies aiming to reduce the risk of relationship distress assessed relationship quality/satisfaction among participants receiving IPT. There were no studies that reported a significant improvement in relationship quality/satisfaction.

 Twelve treatment studies assessed relationship quality/satisfaction among women receiving IPT. Four studies (Chung, 2015; Field et al., 2013; Hajiheidari et al., 2013; Mulcahy et al., 2010) reported significant improvements in relationship quality, with an effect size in the small range. Studies with married/cohabitating participants were more likely to have greater improvements in their relationship quality than those women without partners.

3.8. Change in Social Support Between Treatment and Comparison Groups

Four prevention studies aiming to reduce the risk of distress related to poor support assessed social support among participants receiving IPT. Three of these studies (L. L. Gao et al., 2012; L. L. Gao et al., 2012; L. L. Gao et al., 2015) reported significant improvements in social support. The effect size was in the small range.

Seven treatment studies assessed the change in social support among participants receiving IPT. Three studies (Lenze & Potts, 2017; Lenze et al., 2015; Mulcahy et al., 2010) reported significant improvements in social support. The effect size was in the medium to large range. Studies with participants who had higher levels of education were more likely to experience significant improvements in social support.

3.9. Change in Attachment Levels Between Treatment and Comparison Groups

There were no prevention studies that assessed attachment. There were eight treatment studies that assessed attachment among participants receiving IPT. Three of these studies (Mulcahy et al., 2010; Posmontier et al., 2019; Spinelli, Endicott, Leon, et al., 2013) reported significant improvements in attachment. While these improvements were reported to be statistically significant, the effect size of the IPT intervention was not reported.

3.10. Change in the Level of Adjustment Between Treatment and Comparison Groups

There was one prevention study aiming to reduce the risk of poor adjustment that assessed for adjustment among participants receiving IPT. This one study (Crockett et al., 2008) reported that the level of adjustment was statistically significant only between 2–3 weeks and 3 months postpartum. No effect size was reported.

There were 12 treatment studies that assessed for level of adjustment among participants receiving IPT. There were no studies that reported any significant improvements in level of adjustment.

4. Discussion

This review of the literature provides evidence that IPT is an effective intervention for the prevention and treatment of psychological distress in women during their pregnancy and postpartum period. As a preventive intervention, IPT is superior to comparison conditions, including active interventions, treatment-as-usual, and no intervention, for reducing the risk of depression. As a treatment intervention, IPT is effective in significantly reducing symptoms of depression and anxiety as well as improving social support, relationship quality/satisfaction, and adjustment. IPT is superior to comparison conditions including active interventions, treatment-as-usual, and no intervention for reducing depressive symptoms as well as improving social support and relationship quality.

There is evidence supporting the use of IPT to prevent depression in perinatal women. These findings suggest that IPT is effective as both a prevention intervention and for those women at high risk due to the presence of risk factors including a previous diagnosis of depression (Zlotnick et al., 2006) or post-traumatic stress disorder (PTSD) (Grote et al., 2015; Grote et al., 2017; Zlotnick et al., 2011).
There was one preventive study that reported outcomes for symptoms of anxiety (Bowen et al., 2014). This study found that IPT was effective in reducing anxiety symptoms and worry over time in pregnant women compared to active interventions, treatment-as-usual, and no interventions. Given the far reaching impact of prenatal anxiety on women and their children (Brunton et al., 2015 [87]; Mughal et al., 2019 [88]; Brunton, Dryer, Field, 2017 [89]; K. Bright & Becker, 2019 [90]), future research exploring preventive interventions in prenatal women would benefit from including assessment of anxiety in addition to depressive symptoms. There is a need for investigating the diagnostic outcomes of anxiety and anxiety-related disorders, including the prevalence of perfectionism and obsessive-compulsive disorder, as preliminary work in this area suggests that there is increased risk for these disorders during the perinatal period (Kane, Winton, Eliot, & McEvoy, 2017 [91]; Lowndes, Egan, & McEvoy, 2019 [92]; Standeven, Nestadt, & Samuels, 2020 [93], Buchholz, Hellberg, & Egan, Abramowitz, 2020 [94]).

In this review, group prevention interventions resulted in greater reduction in risk of symptom levels of depressive than individually administered interventions. Groups have a valuable set of therapeutic characteristics where women are provided with a supportive network of peers with shared feelings, thoughts, and problems (Marmarosh, Holtz, & Schottenbauer, 2005) [95]. Women gain insight into the universality of their problems, which helps to normalize their experiences (Reay et al., 2006). Group therapy allows women to increase their coping strategies, knowledge, and skill through vicarious learning. Helping others solve their problems can increase their sense of competence. It may also be that the social skills and competencies gained through group-based IPT prevent the onset of depressive symptoms by specifically moderating relationship challenges.

While RCTs of IPT for mental health disorders show a moderate to large effect on depression compared with control groups, IPT has not been found to be more effective than other psychotherapies such as CBT for depression (Cuijpers, Donker, Weissman, Ravitz, & Cristea, 2016 [96]; Jakobsen, Hansen, Simonsen, Simonsen, & Gluud, 2012 [96]). Research does suggest that pharmacotherapy may be mildly more effective than psychotherapies (Cuijpers et al., 2016 [97]; Cuijpers, van Straten, Andersson, & van Oppen, 2008 [98]). When pharmacotherapy is combined with psychotherapy, it is not more effective than pharmacotherapy alone, but is more effective than IPT alone (Cuijpers et al., 2016 [96]; Nillni, Mehralizade, Mayer, & Milanovic, 2018 [99]).

There was a trend that more studies of individually administered IPT showed a reduction of anxiety symptoms than group offered IPT. Individual therapy has the advantage of participants receiving greater attention to their individual issues, closer monitoring of symptoms, and more tailored adaptation of the intervention to issues that are particularly relevant to the individual (O’Shea, Spence, & Donovan, 2015) [100]. Previous literature reviews and meta-analyses have obtained contradictory findings (Cuijpers et al., 2008; Goodman & Santangelo, 2011; L.E. Sockol, Epperson, & Barber, 2011; L. E. Sockol, Epperson, & Barber, 2013) [97,101–103]. Future preventive and treatment research would benefit from including assessment of acceptability of group and individual therapy. Investigation of potential predictors of treatment efficacy should include a history of depressive disorders and anxiety-related disorders as well as their comorbidity to determine if these characteristics are associated with delivery method and differential efficacy.

In six RCTs examining the effect of IPT on anxiety, compared to other psychotherapies, this resulted in a small nonsignificant difference in favour of the alternative therapies such as CBT over IPT (Cuijpers et al., 2016; Nillni et al., 2018) [96,99]. There is one study investigating the effect of paroxetine and CBT compared to CBT alone and it was found that there was no significant difference between groups (Misri, Reebye, Corral, & Mills, 2004) [104]. Given the paucity of research in this area, this is concerning given that anxiety symptoms and comorbid symptoms are prevalent in perinatal women, therefore it is important that there is further research on effective treatments.
4.1. **Strengths**

There are numerous strengths of this systematic review, which include explicit methods description and comprehensive database searches to methodologically search for articles exploring the use of IPT/IPT-based interventions in the perinatal population. This transparent and systematic approach to reviewing the literature included the use of a librarian for the search and two reviewers with content expertise for the assessment of inclusion and data extraction attempted to reduce reviewer bias. This rigorous process facilitates a reproducible and objective criteria to select relevant studies and adequately assess their quality.

4.2. **Limitations**

A major limitation of the studies evaluating IPT, whether for prevention or treatment, is that few studies addressed outcomes such as social support, relationships, and adjustment the same way. Improving these interpersonal areas are among the goals of IPT. As such, there needs to be consistency in how these elements are operationalized in a perinatal population. Implications for future IPT intervention studies involve assessing perinatal women’s change in interpersonal functioning and involving women’s partners in treatment.

Findings from this review of IPT in perinatal women are limited to IPT being delivered face-to-face or via telephone. Literature examining online IPT in non-perinatal populations suggests that despite high dropout rates, internet-delivered self-guided IPT is effective in reducing depressive symptoms (Donker et al., 2013). Future research requires well-designed RCTs that compare internet-delivered IPT to active, treatment-as-usual, and no treatment. Additionally, internet-based IPT trials will need to assess differences in prevention versus treatment, prenatal versus postpartum women, and group versus individual treatment.

This review is limited by the lack of detailed descriptions of recruitment and retention strategies of the individual studies. Further limitations include the inclusion/exclusion criteria of reviewing only English-language articles, which may reduce generalizability to non-English speaking populations. Similarly, this review included only peer-reviewed literature and excluded government reports, dissertations, conference papers, and reviews. This limited the access to grassroots or community-based recruitment and retention strategies that may have been used to target smaller or marginalized groups of perinatal women.

4.3. **Research Implications**

Further studies would benefit from refinement of the perinatal IPT treatment. In future studies, the IPT intervention will need to include a comprehensive IPT manual to promote adherence/competence measures. Perinatal IPT research will also benefit from development of far-reaching training programs for those delivering IPT in research, community, and clinical settings. Improving the structure of IPT and training of clinicians who can deliver evidence-based IPT has the potential to improve outcomes for perinatal women.

Additional research is required to evaluate the efficacy of internet-based treatment compared to telephone and face-to-face delivery. Regardless of the type or mode of delivery, research aimed at exploring the mechanisms of action is necessary for IPT interventions. This will aid in further refining IPT interventions, improving outcomes, and determining whether the intervention is applicable in additional settings.

Studies exploring various techniques for keeping women engaged in treatment for extended periods of time are warranted to ensure that perinatal women can complete the full IPT intervention. This will take into consideration an individual’s preference for treatment. Longitudinal studies of different intervention models (varying in length and delivery) and social support are needed. More research into how IPT interventions can be implemented as a part of routine prenatal care is needed.
4.4. Clinical Implications

There is a large body of research that demonstrates the effectiveness of treatments for depression and anxiety during the perinatal period (Milgrom, Negri, Gemmill, McNeil, & Martin, 2005; Nillni et al., 2018; L. E. Sockol, 2018; L. E. Sockol et al., 2013) [99,101,102,105]. Given that there is strong evidence for and no difference in the effectiveness for prevention and treatment of various psychotherapies allows for women to determine which psychotherapy they would choose. This choice may also be influenced by the mental health services offered through the trained therapists in their area. Additionally, the decision on whether to use pharmacotherapy in addition to psychotherapy during the perinatal period is complex and requires the consideration of many factors, including the effects of untreated maternal mood and/or medication exposure on both maternal and fetal outcomes. Clinical discussion making around mental health treatment options would benefit from thoughtful conversations between clinicians and the perinatal women as well as their families as no one treatment works for everyone.

5. Conclusions

This systematic review provides evidence that IPT is an effective intervention for the prevention and treatment of psychological distress in women during their pregnancy and postpartum period. This review also highlights the need for robust, high quality RCTs exploring different intervention models for women during the perinatal period.

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List of Abbreviations

| Abbreviation | Description |
|--------------|-------------|
| ANRQ         | Antenatal Risk Questionnaire |
| AQ5          | Attachment Style Questionnaire |
| BAI          | Beck Anxiety Inventory |
| BDI          | Beck Depression Inventory |
| BDI-II       | Beck Depression Inventory |
| Brief-STAI   | Brief State-Trait Anxiety Inventory |
| CAGE-AID     | Questionnaire for Drug and Alcohol Addiction Screening |
| CBT          | Cognitive Behavioral Therapy |
| CBQ          | Child Behavior Questionnaire |
| CES-D        | Centre for Epidemiological Studies Depression Scale |
| CIDI         | Composite International Diagnostic Interview |
| CNM-IPT      | Certified Nurse-Midwife Telephone Administered Interpersonal Psychotherapy |
| CSQ          | Cooper Survey Questionnaire |
| CTS2         | Revised Conflict Tactic Scale |
| CWS          | Cambridge Worry Scale |
| DAS          | Dyadic Adjustment Scale |
| DASS-21      | Depression, Anxiety, and Stress Scale—21 items |
| Acronym   | Full Form                                                                 |
|-----------|---------------------------------------------------------------------------|
| DIS       | Diagnostic Interview Schedule                                            |
| DLC       | Difficult Life Circumstances                                             |
| DSM-IV    | Diagnostic and Statistical Manual of Mental Disorders, fourth edition    |
| DSM-IV-NP | Diagnostic and Statistical Manual of Mental Disorders, fourth edition, non patient version |
| EAS       | Emotional Availability Scale                                             |
| ECR       | Experiences in Close Relationships Scale                                |
| ECR-R     | Experiences in Close Relationships Revisited Scale                      |
| EPDS      | Edinburgh Postnatal Depression Scale                                    |
| EPDS-P    | Edinburgh Postnatal Depression Scale for Partners                        |
| EFCT      | Emotional Focused Couples Therapy                                        |
| EPHPP     | Effective Public Health Practice Project                                |
| GAF       | Global Assessment of Functioning                                         |
| GHQ       | General Health Questionnaire                                             |
| HADS      | Hospital Anxiety and Depression Scale                                   |
| HAM-A     | Hamilton Anxiety Rating Scale                                            |
| HAM-D     | Hamilton Depression Rating Scale                                         |
| HSC       | Hopkins Symptoms Checklist                                               |
| HRSD      | Hamilton Rating Scale for Depression (also written as HAM-D)             |
| IBQ       | Infant Behavior Questionnaire                                             |
| ICD       | International Classification of Disease                                 |
| ICMJE     | International Committee of Medical Journal Editors                       |
| IDD       | Inventory of Diagnose Depression                                         |
| IIP       | Inventory of Interpersonal Problems                                     |
| IPT       | Interpersonal Psychotherapy                                              |
| IPT-G     | Interpersonal Psychotherapy for Groups                                   |
| LIFE      | Longitudinal Interval Follow-up Evaluation                               |
| LIFE-R    | Longitudinal Interval Follow-up Evaluation Revised                       |
| LQ        | Leverton Questionnaire                                                   |
| MAI       | Maternal Attachment Inventory                                            |
| MCMI-II   | Millon Clinical Multiaxial Inventory                                     |
| MDD       | Major Depressive Disorder                                                |
| MFB       | Mindfulness Based                                                        |
| MINI      | MINI-International Neuropsychiatric Interview                            |
| M-ITG     | Mother-Infant Therapy Group                                              |
| MSSS      | Maternity Social Support Scale                                           |
| OT        | Open Trial                                                               |
| PLC-C     | Post-traumatic Stress Disorder Checklist–Civilian Version               |
| PES       | Peripartum Events Scale                                                 |
| PHQ       | Patient Health Questionnaire                                             |
| PHQ-9     | Patient Health Questionnaire Revised                                     |
| PPAQ      | Postpartum Adjustment Questionnaire                                      |
| PPD       | Postpartum Depression                                                    |
| PRISMA-P  | Preferred Reporting Items for Systematic Reviews and Meta-analyses       |
| PSI       | Parenting Stress Index                                                   |
| PSOC      | Parenting Sense of Competence Scale                                      |
| PSOC-E    | Parenting Sense of Competence with Efficacy Scale                        |
| PSR       | Psychiatric Status Rating                                                |
| QRT       | Quasi-Randomized Controlled Trial                                        |
| RCT       | Randomized Controlled Trial                                              |
| ROSE      | Reach out, Stand Strong                                                  |
| SAS       | Social Adjustment Scale                                                  |
| SAS-SR    | Social Adjustment Scale Self Report                                      |
SCID Structured Clinical Interview for DSM
SCID-I Structured Clinical Interview for DSM I
SCID-IV Structured Clinical Interview for DSM IV
SCL-90 Symptoms Checklist 90 Questions
SSQ-R School Situations Questionnaire-Revised
STAI State-Trait Anxiety Inventory
STAXI State-Trait Anger Expression Inventory
SUD Substance Use Disorders
TAU Treatment as Usual
TSR Treatment Services Review
WSAS Weinberg Screening Affective Scales
WLC Waitlist Control

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