Interpersonal Psychotherapy for Postpartum Depression

A Treatment Program

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Postpartum depression is a frequent complication of childbirth. Postpartum depression is associated with disruptions in interpersonal relationships, and the puerperium is a period of major role transition. In contrast to other subtypes of depression, however, postpartum depression often is not treated with medication, which is relatively contraindicated for women who are breastfeeding. Interpersonal psychotherapy (IPT) focuses specifically on the effects of depression on interpersonal functioning; this focus renders IPT a potentially useful psychosocial treatment for postpartum depression. The authors describe the use of IPT for the treatment of women with postpartum depression and present preliminary results from an open treatment trial of IPT.

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Interpersonal psychotherapy[1] (IPT) is a time-limited, interpersonally oriented psychotherapy that has been empirically demonstrated to be effective in the treatment of depression. Grounded both in the interpersonal theories of Harry Stack Sullivan[2] and the attachment theories expounded by Bowlby[3] and others, IPT is based on the hypothesis that patients who experience social disruptions are at increased risk of developing depression.[4] IPT specifically targets patients' interpersonal relationships as a point of intervention and is designed to assist patients in modifying either the relationships themselves or their expectations about their relationships.

IPT has been used both to treat acute episodes of depression and as a long-term measure to prevent depression. IPT is significantly more effective in the treatment of acute depression than no treatment,[5,6] and it has also been shown to be superior to a placebo medication treatment for depression.[7] In addition, the use of IPT results in significantly greater protection from relapse of depression when depressed patients who receive IPT are compared with those who receive no treatment.[8]

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IPT has also been used as a primary treatment and as an adjunct to antidepressant medication in preventing relapse in patients who have recovered from an episode of major depression. The combination of IPT and imipramine has been shown to afford significantly more protection against relapse than antidepressant medication alone.[9] Monthly sessions of IPT alone, although not as effective as imipramine, nevertheless lengthened the interval between episodes of depression when patients receiving IPT were compared with those receiving placebo medication.[10–12]

Additionally, IPT has been used in the treatment of other affective disorders. It has been shown to be effective in the treatment of depressed patients with HIV infections,[13] and it has been used to treat bipolar patients[14] and medically ill patients with secondary depression.[15] IPT has also been used with patients suffering from dysthymia[16] and for adolescents with depression[17] as well as depressed geriatric patients.[18]

Despite the documented efficacy of IPT in the treatment of depression, the recent development of newer and less toxic antidepressant medications has led to the use of medication as the treatment of choice for most types of depression.[19] Psychotherapy is, however, a treatment of choice in depressions associated with pregnancy both in the prenatal and postpartum periods because medication is relatively contraindicated during these times.[20] Although antidepressants can be used, most experts agree that they should be used with caution because medication may have an effect on the developing fetus or the breastfeeding newborn.[21] Consequently, the need to develop psychological treatments for these disorders is paramount.

POSTPARTUM DEPRESSION: OVERVIEW

Recent studies of psychological functioning in the postpartum period have revealed that postpartum depression is a common disorder with a high degree of morbidity. The incidence of postpartum depression has been estimated to range from 7%[22] to 16%[23] across all childbearing women. Women with postpartum depression typically have more severe depressive symptoms than women who experience depression unrelated to the postpartum period,[24] and long-term follow-up of women experiencing postpartum depression has shown that such women are at higher than normal risk for recurrent episodes of depression.[25]

Patients with postpartum depression typically have physiologic symptoms that are similar to those of depression uncomplicated by childbirth. DSM-IV, in fact, has categorized postpartum depression as a type of major depression and has added the longitudinal specifier "with postpartum onset" to describe episodes of major depression that begin within 4 weeks postpartum.[26] Depressed mood, decreased energy, difficulty in sleeping, and appetite disturbances are common. In addition, many women feel hopeless and occasionally develop suicidal ideation. Concentration is often decreased, and women with postpartum depression may tend to isolate themselves. Feelings of inadequacy or guilt, related particularly to the patient's ability to care for the newborn, are also common.

Interpersonal Functioning

As occurs with women who experience depression not associated with childbirth, women with postpartum depression have been shown to have numerous disruptions in their interpersonal relationships. Although interpersonal disturbances are not specific to postpartum depression, a number of typical disruptions appear to be associated with the postpartum period.

Depressed women report a significant discrepancy between the level of social support they desire during the postpartum period and the level they feel they have actually received.[27] This lack of perceived support occurs in women's relationships with parents, relatives, and friends, but it is most pro-

nounced in their relationships with their husbands. The interpersonal relationship between patients and their spouses is reported to be more impaired with postpartum women suffering from depression than with those who are not depressed.[24] Depressed women's marital relationships during the postpartum period may be further stressed by the couple's differing perceptions of the situation. Husbands typically report better adjustment for their spouses than postpartum women indicate is the case when they assess their own adjustment. Husbands often do not share the perception of their depressed wives that others are not providing adequate social support, nor do they perceive that they are not adequately supporting their spouses. This lack of perceived support from significant others during pregnancy has been shown to be a specific risk factor for the occurrence of postpartum depression.

Psychosocial Interventions

Despite a clear need for psychosocial treatments for postpartum depression, relatively few studies have investigated the efficacy of such interventions for postpartum depression. Gordon and Gordon[28] and Halonen and Passman[29] conducted prevention studies in which pregnant women received psychoeducational classes (in the former study) or relaxation training (in the latter study) during the prenatal period. Both noted that the incidence of subsequent postpartum depression was reduced in the women studied compared with a control group. Cowan and Cowan[30] and Elliott et al.[31] also conducted prevention treatment trials, using psychoeducational groups that met during both the prenatal and postpartum periods. In both of these studies, the groups receiving treatment had a significantly reduced incidence of postpartum depression compared with no-treatment control groups. At present, however, there are no data indicating which women at risk for depression are likely to benefit from preventive treatment, making widespread use of this treatment economically untenable.

Four reports have described the treatment of women experiencing postpartum depression. Morris[32] published a case report of 7 women with prolonged episodes of postpartum depression who were treated in a weekly psychotherapy group for 11 months. Although significant reductions in Beck Depression Inventory[33] (BDI) scores at the end of treatment were noted, the scores were not reported. In addition, it is not clear what criteria were used at intake to diagnose the women as depressed.

Clark et al.[34] reported on a group psychotherapy treatment of 13 women described as having symptoms of postpartum depression. The group met for 12 weeks, and the treatment also included individual treatment for the infants of the participants. Unfortunately, the report did not include any description of the patients treated, nor were any diagnostic criteria used to confirm the presence of depression. The mean BDI scores for this group were reported to have decreased from 18.9 before treatment to 12.1 at termination.

Fleming et al.[35] described a study in which women diagnosed with postpartum depression were nonrandomly assigned to one of three treatments, including participation in a social support group for 8 weeks, a "group by mail" condition in which women received short scripts of the group sessions but had no contact with the group, and a no-treatment control group. Both depressed and nondepressed women were included in the social support groups. Although more than 90% of the women receiving group treatment reported that it was beneficial, women in the social support group fared no better than women in the other two groups when their symptoms of depression were compared. In addition, the women in the social support group showed less improvement in negative self-image than the women in the no-treatment control group.

The most rigorous study to date was conducted by Holden et al.,[36] who studied a

group of postpartum women who met the Research Diagnostic Criteria[37] for major depression. Sixty women were randomly assigned either to treatment (eight weekly in-home visits from a visiting nurse who was trained in Rogerian and nondirective counseling) or a no-contact control group. At the conclusion of the 3-month treatment trial, 69% of the treated women no longer met RDC criteria for depression, compared with only 38% of the women in the control group. Edinburgh postnatal depression scores[38] decreased from 16.0 to 10.5 in the treated group by the end of treatment as compared with a decrease from 15.5 to 12.0 in the control group. Although the difference in change scores is statistically significant, the magnitude of change is relatively small even for the treated group. The scores of both groups at termination indicate that the women in the study continued to have marked symptoms of depression at the end of treatment.

In summary, there are very limited data regarding the effects of psychosocial interventions for the treatment of postpartum depression. The existing data do not demonstrate that psychoeducation or supportive psychotherapy is beneficial to women suffering from postpartum depression. Although psychoeducational interventions intuitively would be expected to be of benefit for these women, it may be that the interventions studied to date have been less than optimally effective because they have not targeted some of the major interpersonal problems experienced by women during the postpartum period. Psychosocial interventions that are theory driven and that target the specific symptoms and interpersonal disruptions experienced by women in the postpartum period would be expected to be more effective in the treatment of the disorder.

IPT FOR POSTPARTUM DEPRESSION: OVERVIEW

IPT is designed to treat depression by helping patients to focus on four different interpersonal problem areas: role transitions, interpersonal disputes, grief, and interpersonal deficits. Once an initial assessment is completed, therapist and patient collaborate to choose a specific problem area and begin working on that issue. Because IPT is a short-term therapy, it is possible to cover only a limited number of issues during the treatment.

IPT requires several modifications for use with women who are experiencing postpartum depression. A careful initial evaluation must be completed because postpartum women who are not depressed often experience changes that might in other contexts be construed as symptoms of depression. The care of a newborn, for instance, almost invariably leads to sleep disruptions and decreased energy, and it may lead to other vegetative symptoms frequently experienced during depression, even in postpartum women who are not depressed. Care must be taken to qualitatively ascertain that the physical symptoms reported by postpartum women are more severe than those that would normally be expected during this time period.

The postpartum period is one of major role transition; that is, a time in which patients are required to change or add to their various life roles. This is particularly true for women who are primiparous. Difficulties in becoming pregnant, unwanted pregnancies, complications in the prenatal course, and problems in labor can all complicate the course of postpartum depression and require careful assessment. Finally, there are often practical considerations for women with postpartum depression, such as finding child care so that patients can attend the sessions.

Conducting IPT Sessions

Session 1: A number of tasks must be accomplished during the initial session with a woman who has postpartum depression. The therapist must completely assess the symptoms of depression, begin an interpersonal inventory, and identify a problem area on

which to focus treatment. In addition, several practical issues should be addressed.

As noted above, the therapist should focus on ascertaining whether the symptoms of depression reported by women with postpartum depression are qualitatively different from those that would be expected in postpartum women not experiencing depression. The therapist must also assess the severity of depression and the presence of suicidal ideation to determine if treatment with medication or hospitalization is required. Patients who meet criteria for depression should be told about their diagnosis, and a brief psychoeducational intervention should follow. Typically, patients are told that 1) they are suffering from postpartum depression; 2) postpartum depression is a legitimate medical illness; 3) postpartum depression and depression in general are relatively common; and 4) there are specific treatments available for depressive illnesses. Offering a medical model for postpartum depression serves to remove any sense of guilt that patients may have, and the information regarding treatment is designed to foster patients' hope for recovery.[1] Labeling the depression as "postpartum" also implies that it is related to a specific cause and will be time-limited—that is, it will resolve when the stressors are reduced and the patient completes the transition through the postpartum period.

The therapist should place the patient's depressive symptoms in an interpersonal context as the interpersonal inventory begins. The inventory should focus primarily on the expectations that the patient had prior to childbirth, particularly her expectations for social support from her spouse, parents, and significant others. The information obtained should include the interactions between the patient and her significant others, the expectations of the parties in each relationship, the satisfactory and unsatisfactory aspects of each relationship, and the ways in which the patient would ideally like to change the relationships. Information must also be collected regarding the patient's expectations about motherhood and her feelings about her child and their relationship. It is essential to obtain information on the planning of the pregnancy, the course of the pregnancy, and the labor and delivery process.

Roughly three-fourths of the way through the session, the patient and therapist should work together to identify a specific problem area. It is the therapist's job to help the patient formulate the focus as specifically as possible. For instance, if the patient says that she wishes to have "more help" from her husband, then the therapist should assist the patient in defining more specifically what type of help she wants—for example, help with cleaning the house or with infant care. At this point in treatment the problem focus is considered tentative until more information is collected.

After the focus has been identified, the therapist should give the patient a brief description of IPT, including its rationale and purpose. The patient-therapist interactions to this point should have served to set the stage for this explanation in that the therapist has already begun to take an active stance in therapy and has begun to emphasize the interpersonal aspects of the therapy. The four problems areas covered in IPT (role transitions, interpersonal disputes, grief, and interpersonal deficits) should be explained in layman's terms to the patient. It is often helpful to apply one or more of these to an example obtained from the patient during the interpersonal inventory. It should also be specifically stated that IPT is efficacious in the treatment of depression and that it has been shown to be effective within a limited time frame.[1]

The patient's role in IPT should also be described. The patient is expected to discuss openly with the therapist her relationships and problems with significant others. The patient is also expected to take responsibility for the topics to be discussed in therapy and to actively work with the therapist to solve problems that are identified.

In the first session, the patient-therapist

contract must be explicitly discussed. A firm 12-session limit should be established, and a schedule for frequency of meetings should be agreed on. The session should not be concluded until a specific time for the next appointment has been set. Procedures to follow in case of an emergency should also be explained to the patient. To conclude, the therapist briefly summarizes the first session for the patient.

Session 2: As a means of focusing the patient on the need to take an active role in treatment and in creating change, the therapist should begin each subsequent session by asking about the events of the past week specifically related to the problem area that was discussed previously. For instance, if the patient and therapist had focused on the patient's relationship with her husband, the therapist should inquire into how the relationship went over the last week, any changes that may have occurred, and any changes in the patient's perceptions of the relationship. Opening the session in this way conveys to the patient that she is responsible for changing her behavior and that she has the power to positively affect her relationships. After this, the therapist may ask an open-ended question such as "What shall we discuss today?" if the discussion does not naturally evolve.

The second session should focus on completing the interpersonal inventory. The problem area should be covered in detail, with the aim not only of collecting information but specifically identifying the exact problems in the patient's relationships. The patient and therapist should agree on a specific focus for the next several sessions by the end of the second session.

Intermediate Sessions: Treatment in the intermediate sessions should focus on one or more of the four IPT problem areas: role transitions, interpersonal disputes, grief, and interpersonal deficits. In our experience, most cases of postpartum depression can be conceptualized as role transitions. The exceptions to this rule are typically patients who have extensive previous psychiatric histories. The formulation of postpartum depression as a role transition is of use for several reasons. Primarily, it provides a reasonable rationale that makes intuitive sense to patients and permits them to understand their problems. In addition, it implies that the depression will be time limited.

Problem Areas

Role Transitions: Role transitions in the postpartum period are typically associated with the need to develop new skills and expand the breadth of the patient's responsibilities even as old relationships are maintained. The patient often finds herself in the position of having to juggle several different roles and the increased demands from all of the relationships attached to those roles. A decrease in self-esteem is often the result, as well as confusion about which relationships and responsibilities should be given priority. Although it is infrequent that familiar social supports are lost entirely, they often have to be modified to a large extent.

The goal of the IPT therapist in the postpartum period is not to help the patient give up her old roles, but rather to assist her in combining her new roles with those she has already established. The therapist should encourage the patient to express the emotions attached to each of the roles and to explore ambivalent feelings about each. Developing a more balanced view of each role assists the patient in modifying expectations and restructuring priorities.

A typical example of the type of role transition that might be expected in the postpartum period is a working woman who is now faced with the role of mother in addition to her previous roles of spouse and employee. In such a situation, the patient faces the prospect of becoming overwhelmed if she is unable to reassess her priorities and time commitments and to adapt to her new time and emotional constraints. A spouse or em-

ployer who is resistant to change could easily exacerbate the problems faced by the patient. One treatment strategy would be to help the patient identify the types of relationships she has with her spouse and her employer and assess the degree of satisfaction she receives from each. The patient should be assisted in developing a balanced view of her needs and the degree to which they are being met. Her expectations of both her husband and employer should also be assessed. Most important, her expectations regarding caring for a child, her experiences during pregnancy, and her expectations of support from others should be reviewed.

After this comprehensive review, the patient should be assisted in problem solving—that is, in developing a specific problem focus, "brainstorming" to develop potential solutions, evaluating the possible solutions, implementing a plan of action, and assessing the results of the action. Possible solutions might include asking her spouse to assume more child care responsibilities, decreasing the amount of time spent at work or requesting more flexible hours, or finding alternative child care. The actual solution, of course, is less important than teaching the patient to assess her interpersonal relationships and empowering her to change those areas she finds problematic.

In addition, it is important that the patient be made aware that others in her interpersonal sphere have also undergone significant role transitions. The patient's husband or significant other must also make significant adjustments as he takes on the role of father. The same is true to a lesser degree for members of the extended family. As the patient begins to appreciate that others are in a transition period as well, she is able to shift from a blaming stance to one in which negotiation with her significant other is possible.

Case 1. K.A., a 29-year-old primiparous woman, sought treatment for her postpartum depression at 4 months postpartum. She reported a normal pregnancy and delivery. At intake, she complained of a depressed mood, difficulty in sleeping, poor appetite, lack of energy, and, most problematic, a strong feeling of anhedonia. She denied any suicidal ideation; however, she reported that she was functioning at a "minimal level" and consequently had feelings of guilt and low self-esteem.

The patient had been married for 5 years and had been extremely successful academically during that time, having received several awards as a graduate student. During her pregnancy, she had held a teaching position and a research assistantship and had begun work on her dissertation. She reported that she had anticipated that she would be able to continue with all of these activities after her delivery.

After the birth of her child, she reported that she was no longer able to keep up her work on her dissertation, had feelings of guilt over the lack of time spent with her husband and friends, and also felt under a great deal of pressure from her dissertation advisor. Her method of coping was to pour most of her energies into her relationship with her child.

Treatment focused initially on educating the patient about normal postpartum experiences and helping her to appreciate that her expectations may have been unrealistic. The problem was defined as a role transition, and a strong message was conveyed to the patient that she would be able to gradually adapt to the situation and resume her previous high level of functioning, albeit with some modifications. Treatment then focused on helping the patient to modify some of her interpersonal relationships. This included restructuring her relationships with her fellow students, with whom she was able to schedule time for activities rather than being drawn into spontaneous activities as she had been previously. She was able to ask her husband to take on more of the child care and housework responsibilities she had previously managed, freeing some time for herself and for work on her dissertation. Finally, she was able to confront her advisor about the pressure she felt and was able to negotiate a more realistic schedule for completion of her academic work.

At the conclusion of treatment, the patient reported that her life had become much more manageable. Although she felt she had lost some of her ability to be spontaneous, she had reorganized her life in such a way that she was able to adapt to her time constraints.

Interpersonal Disputes: One of the most significant potential stressors in the postpartum period is the relationship between the patient and her spouse. The reactions of the patient and her husband during the postpartum period may be quite different, and there are commonly differences in the degree to which each spouse feels that adjustment to the newborn has been made. A thorough assessment of the patient's expectations regarding child care should be conducted, specifically focusing on the roles that the patient expected herself and her husband to play. Other significant people, including parents, in-laws, and other children should also be included in the assessment. The way these relationships evolved during the pregnancy should be explored, as should the status of the relationships prior to the pregnancy.

The first step in dealing with these interpersonal disputes is to identify or "diagnose" the dispute. Once the problem is identified, a problem-solving approach should be taken, and the patient should be assisted in developing and carrying out a plan of action. The patient's expectations should be explored and can be compared with the expectations of the other party in the relationship. Once the patient's expectations are made clear, a brainstorming approach allows exploration of the options for modifying the relationship. Modifications with which the therapist might assist the patient include changing or lowering her expectations of her spouse, developing a more balanced set of expectations about the newborn, and developing new sources of support. In addition, the patient should be encouraged to take an active role in changing the relationship by changing her patterns of interaction with the person with whom she is having the dispute. Continual use of the problem-solving method will allow for adaptations in communication or expectations as the patient's attempts to resolve the dispute unfold.

It is often helpful to include the patient's husband or significant other in one or two therapy sessions when therapy has reached this point. Including the partner provides more information about the patient's behavior, permits detailed examination of the point of view of the other party in the dispute, and allows the therapist to observe the interactions of the patient and her significant other. Although marital therapy is not an intrinsic part of IPT for postpartum depression, conducting one or two conjoint sessions is often extremely helpful in resolving interpersonal disputes.

Communication analysis is a frequently used technique when dealing with interpersonal disputes in the postpartum period. Role-playing can be used to provide an in-depth look at the communication patterns in the relationship, and it is often helpful to have the patient play the role of the significant other with whom she is having the dispute as a means of developing insight into the reactions of that person. This switching of roles is particular to IPT for postpartum depression because it is often effective in helping patients appreciate the role transitions that the significant other is undergoing during the postpartum period.

Case 2. A.J., a 26-year-old woman 3 months postpartum, described feelings of guilt, a depressed mood, and sleep difficulties. Although she had no complications during pregnancy or labor, she reported that her recovery from the delivery was prolonged compared with that after her first child was born 3 years earlier. She had been married for 4 years.

The patient said that much of her depression was related to conflict in her relationship with her husband. Although she reported that he had been helpful after the birth of their first child, following the arrival of their second child she felt that he had withdrawn and had not helped her with the care of the newborn. She reported that he focused entirely on their older child to the neglect of the newborn and the patient herself.

The patient was asked to role-play in therapy, with the therapist taking the part of the patient and the patient the role of her husband. The role-playing was effective in helping the patient to appreciate that her husband was undergoing some stress as well and that her

complaining style of communication might be perceived by him as critical. She subsequently modified her approach and found him amenable to taking on more of the child care responsibilities as she began spending more time with their older child.

The patient's husband, who had initially been opposed to the patient's participation in therapy, agreed after seven sessions to come with the patient as an adjunct participant to her treatment. During the session, he described feeling neglected by his wife and brought to light some conflicts in their sexual relationship. The patient described feeling reluctant to participate in sexual activity for fear she would become pregnant again, particularly because the most recent pregnancy had been unplanned. The therapist provided the couple with information about the normal course of sexual activity postpartum and also provided them with information about birth control alternatives. The patient completed the last four sessions of therapy by herself and noted that the relationship issues with which she had initially presented were greatly improved.

Grief: In the postpartum period, patients may have grief issues that coincide with the arrival of the newborn. Grief reactions may occur with the death of the newborn or a significant other during the neonatal period. Delayed grief reactions may also occur if patients have put off mourning the loss of a significant other during pregnancy. Therapeutic goals include facilitating the mourning experienced by the patient and helping her to develop relationships that substitute for the relationships that have been lost.

Interpersonal Deficits: In the postpartum period, the attachment between mother and infant is crucial in the development of the infant's sense of security and safety. Consequently, the identification of interpersonal deficits is very important because it is essential that the mother be assisted in developing a nurturing relationship with her child. Providing education to the patient regarding care of the infant and normal child development is paramount. Taking care not to function as a substitute for relationships outside of therapy, the therapist can help the patient practice interpersonal skills that can be used in the development of future relationships. The therapist often needs to take a more active role in helping the patient find other social supports and may need to provide direct encouragement to the patient to make use of these resources.[1]

Specific IPT Techniques

All of the techniques common to IPT for depression are used in postpartum depression, but some additional IPT techniques are specific for postpartum depression. Although these techniques may be used differently in each problem area, they are typically used to some degree in IPT for postpartum depression regardless of the problem focus.

The most commonly used specific technique is psychoeducation. Although noted as useful in IPT for depression,[1] psychoeducation is used much more often in the treatment of postpartum depression. In the initial sessions, the therapist not only provides information about the nature and course of postpartum depression itself, but often must provide information about child development and child care as well. Psychoeducation can be exceptionally helpful if used in conjoint sessions; the father of the child may be quite unaware of the postpartum changes that the patient has undergone, not to mention being unaware of child development issues. It is common in our experience that issues regarding sexual relations are problematic postpartum, and psychoeducational information provided to both the patient and her significant other is often invaluable in helping to resolve these types of problems.

Communication analysis is also frequently used in IPT for postpartum depression. Discussion of a specific incident in an interpersonal dispute, including a repetition of the dialogue, can help the therapist and patient to identify ways in which the communication may be ambiguous or misleading. The

patient may be helped to identify her incorrect assumptions that she has communicated clearly and to identify assumptions that she has understood the communication of others.

Role-playing is a specific form of communication analysis that we have found to be particularly useful in helping patients gain insight into their interactions with their spouses. IPT for postpartum depression includes the modification of having the patient take the role of her husband while the therapist plays the part of the patient in the dispute. Role reversal helps the patient to appreciate her husband's point of view and to recognize that he too is undergoing significant role transitions.

Although the therapist's role in IPT is an active one, a position in which the therapist frequently offers advice is to be avoided. IPT for postpartum depression, however, is typically quite directive in several areas. These include direct intervention by the therapist on practical issues that may interfere with therapy, such as assistance in finding child care resources. In addition, the therapist may give direct advice to the patient regarding child care issues, such as problems in nursing or feeding or helping the child to sleep through the night. If possible, of course, the therapist should help the patient develop problem-solving techniques rather than advise the patient.

Termination

It should be made clear to the patient at the outset of treatment that IPT for postpartum depression is not a "miracle cure," but rather a way to assist patients in their own recovery and a method through which patients can be taught skills that facilitate recovery and reduce the likelihood of relapse. The goals of termination are therefore to facilitate the independent functioning of the patient, to end the relationship with the therapist, and to help the patient develop a sense of competence in dealing with interpersonal problems that she can rely on in the event of future difficulties.

Most therapists typically underestimate the degree of attachment that forms between themselves and their patients, especially during the course of short-term therapy. Termination should be explicitly discussed with the patient during the last several therapy sessions and may be acknowledged as a time of grieving by the patient. The therapist should clearly emphasize the patient's gains in therapy. It is also useful to work with the patient to anticipate any future problems and to begin work on dealing with them.

CLINICAL DATA

Women between 2 and 6 months postpartum (average 4.1 months postpartum) who met criteria based on the DSM-III-R[39] criteria for a major depressive episode were eligible for the IPT for postpartum depression trial. Postpartum depressed women were either referred by their obstetricians or were identified through community screening. After giving informed consent, 12 women were initially accepted into the study; 3 of them declined to participate in treatment. A total of 6 women have completed therapy, 2 terminated treatment within the first 2 sessions, and 1 is currently in treatment. All patients were married. Their ages ranged from 26 to 38 years, and all had at least some college education. All of the participants were working at least part-time during therapy. Five of the 6 patients who were treated were breastfeeding.

Overall, the 6 patients who have completed therapy had an excellent response to treatment. These patients had a mean initial BDI[33] score of 27.7 ± 5.7 (SD) and a mean Hamilton Rating Scale for Depression[40] (Ham-D) score of 18.2 ± 6.2. The mean termination BDI score was 5.4 ± 4.8, and the mean termination Ham-D score was 5.2 ± 4.1. The changes for both measures were significant at $P = 0.02$ (two-tailed t-test, $df = 5$). None of the patients met criteria for major depressive episode at the end of treatment. With respect to response to treatment, the

recovery criteria of the NIMH collaborative study[7] were used for the BDI (BDI ≤ 9) and the Ham-D (Ham-D ≤ 6). Four of the 6 patients had BDI scores of 9 or less at termination, and 4 of the 6 patients had Ham-D scores of 6 or less at termination.

Two patients who requested medication received fluoxetine at 20 mg/day in addition to IPT. The patients on medication did not differ from the nonmedicated patients with respect to age or time postpartum. The two patients on fluoxetine had initial BDI scores of 27 and 25 and initial Ham-D scores of 22 and 13, respectively. At the completion of treatment, these patients had BDI scores of 5 and 2 and Ham-D scores of 12 and 1, respectively. In contrast, the average initial BDI score of patients who received IPT alone was 28.5 at intake and 5.0 at termination, and their average Ham-D score was 21.5 at intake and 4.8 at termination.

CONCLUSION

There is a clear need to develop psychosocial interventions for the treatment of postpartum depression. Women with postpartum depression typically experience a multitude of stressors that are associated with their depression, including a number of disrupted interpersonal relationships. Most pronounced are those with the spouse or significant other, but the transitions that occur in the postpartum period usually affect almost all of a woman's relationships. Because of these interpersonal disruptions associated with postpartum depression, IPT appears to be well suited to treatment of this disorder. IPT offers a specific, problem-focused, and short-term approach to the treatment of postpartum depression.

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