Do preventive psychosocial and psychological interventions reduce the risk of postpartum depression (PPD)?

**METHODS**


*Study selection and assessment:* randomised controlled trials (RCTs) of preventive psychosocial or psychological interventions with a primary or secondary aim of reducing the risk of PPD in pregnant women and new mothers (<6 wks postpartum). Methodological quality of individual studies was assessed.

*Outcome:* main outcome was PPD.

**MAIN RESULTS**

15 trials (n = 7697) met the selection criteria. Most trials (n = 10) defined PPD as scores >12 on the Edinburgh Postnatal Depression Scale (EPDS). Meta-analysis showed that, in general, psychosocial and psychological interventions did not prevent PPD (table), whereas those directed at the general population did not (8 trials).

**CONCLUSIONS**

Generally, preventive psychosocial and psychological interventions do not reduce risk of postpartum depression. However, home visits by professionals, interventions initiated postnatally, and those directed at high risk women may reduce risk of postpartum depression.

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**Preventive psychosocial and psychological interventions vs usual antenatal, intranatal, or postnatal care for postpartum depression (PPD)**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Number of trials (n)</th>
<th>Intervention</th>
<th>Usual care</th>
<th>RRR (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD (variously defined)**</td>
<td>15 (7697)</td>
<td>10%</td>
<td>13%</td>
<td>19% (~2 to 35)</td>
<td>10 (9 to 100)</td>
</tr>
<tr>
<td>PPD (EPDS score &gt;12)**</td>
<td>10 (6126)</td>
<td>13%</td>
<td>14%</td>
<td>9% (~15 to 27)</td>
<td>6 (3 to 12)</td>
</tr>
<tr>
<td>Subgroup analyses (intervention characteristics)†</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individually based</td>
<td>11 (6642)</td>
<td>10%</td>
<td>15%</td>
<td>24% (0 to 41)</td>
<td>20 (10 to 100)</td>
</tr>
<tr>
<td>Home visits by professionals</td>
<td>2 (1663)</td>
<td>14%</td>
<td>21%</td>
<td>32% (16 to 45)</td>
<td>15 (9 to 34)</td>
</tr>
<tr>
<td>Postnatal period only*</td>
<td>10 (6379)</td>
<td>9.4%</td>
<td>15%</td>
<td>24% (2 to 42)</td>
<td>17 (10 to 100)</td>
</tr>
<tr>
<td>At risk women only*</td>
<td>7 (1162)</td>
<td>12%</td>
<td>18%</td>
<td>33% (11 to 49)</td>
<td>17 (10 to 50)</td>
</tr>
</tbody>
</table>

*EPDS = Edinburgh Postnatal Depression scale; other abbreviations defined in glossary. Weighted event rates, RRR, NNT, and CI calculated from data in article. Duration of follow up ranged from 3–24 weeks postpartum; all outcomes reported for final study assessment.

**Commentary**

The systematic review by Dennis and Creedy provides a unique contribution to the literature on the prevention of PPD. The finding that psychosocial and psychological interventions, in general, do not prevent PPD might be a result of study heterogeneity and the quality of the 15 RCTs. Nevertheless, 3 types of intervention appear to reduce PPD: home visits by health professionals, interventions initiated postnatally, and those directed at high risk women. Home visits by health professionals often include multiple interventions that are not described in detail in the trials reviewed. Nurses therefore must rely on theories and other research to guide home visiting practices. Interventions to change negative thinking are indicated as a strategy for women at risk of depression and have been used successfully in other populations and in the management of PPD. Interventions initiated prenatally and continued after the birth were not effective, whereas those that began after the birth were effective. This might be explained by the fact that interventions started prenatally are anticipatory in nature, whereas those that begin after birth can focus on actual problems that contribute to depression. The finding that interventions for high risk women were more successful than those for the general population is relevant for decision making about programming and resource allocation. Targeted interventions are likely to have lower costs than those offered universally. Future research should address the methodological limitations of previous studies (e.g., inadequate sample sizes and high attrition), clearly describe details of the intervention and its intensity, and establish which specific interventions work for women with which characteristics and why.

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Review: some specific preventive psychosocial and psychological interventions reduce risk of postpartum depression

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