

**INTERPERSONAL PSYCHOTHERAPY TO REDUCE
ANTENATAL DEPRESSION: EVIDENCE-BASED NURSING**



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Thematic Paper
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**INTERPERSONAL PSYCHOTHERAPY TO REDUCE ANTENATAL DEPRESSION:
EVIDENCE – BASED NURSING**

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ABSTRACT

Antenatal depression is one of the major health problems and the number of women with antenatal depression is increasing day by day, worldwide. The aim of this study was to analyze and synthesize evidence related to interpersonal psychotherapy for reducing antenatal depression. The author used the PICO framework as a guideline for searching and identify keywords. The keywords used were pregnant women, antenatal depression, and interpersonal psychotherapy. From various electronic databases, the author found a total of five relevant research studies, which contained quality in terms of validity, reliability and application of the evidence. These were three RCTs, one quasi- experimental and one pretest-posttest design research that were published in English from 2003 to 2014.

After analyzing and synthesizing the evidence, it can be recommended that there are two types of interpersonal psychotherapy (IPT) for reducing antenatal depression. The first type is IPT for women, which meet the criteria of a major depressive disorder. The second type is IPT for women with mild to moderate depression. Both types of IPT can be conducted by individuals or using a group method. Furthermore, it can include their partner and grandparents participating in the group. The outcome of the IPT program should be conducted by using The Edinburg Postnatal depression scale (EPDS). It is suggested that the clinical practice guidelines on women with mild to moderate depression, for antenatal depression management, should be developed and implemented among mothers with antenatal depression in the antenatal clinic.

**KEY WORDS: ANTENATAL MOTHER / ANTENATAL DEPRESSION /
INTERPERSONAL PSYCHOTHERAPY / EVIDENCE-BASED
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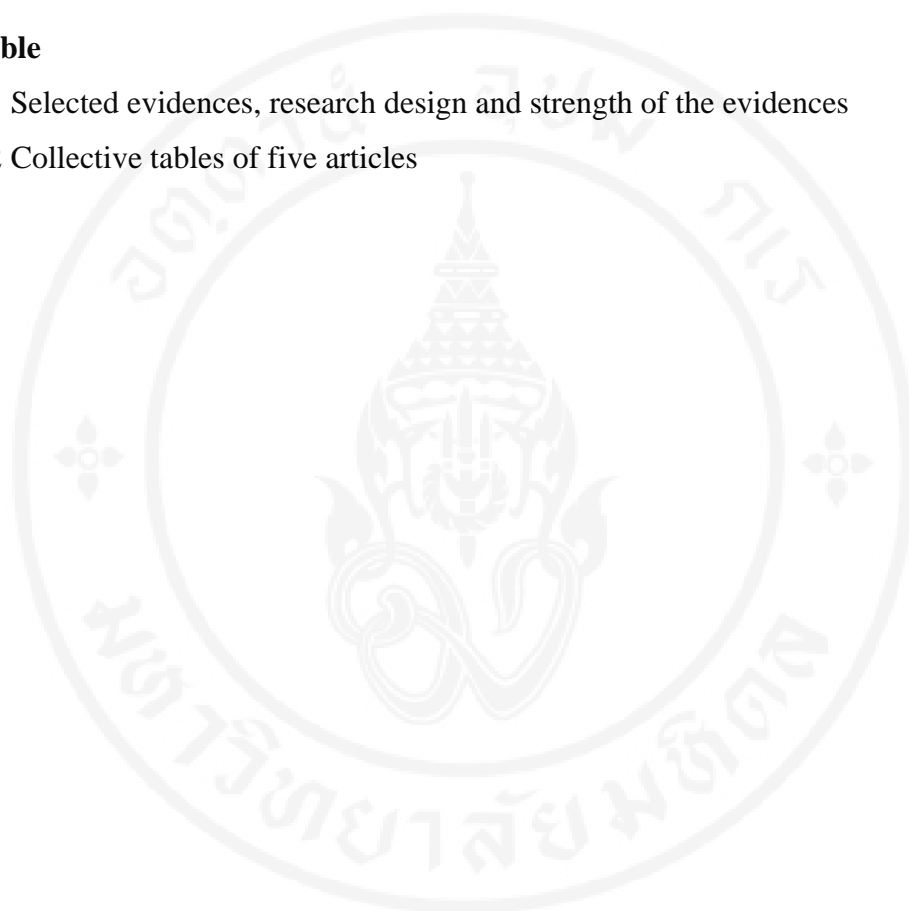
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CHAPTER I

INTRODUCTION

1.1 Background and significance of the problem

1.1.1 Prevalence of antenatal depression

Depression is one of the most common mental illnesses globally and it is estimated that 350 million people suffer from depression worldwide. The World Health Organization (WHO) declared that depression will be the second cause of global disease by 2020. Depression is a form of mood alternative and emotional response that hampers everyday activities. Long-term suffering from moderate to severe depression affects the individual's health condition, work life and daily activities. Eventually, depression may lead to suicide from which approximately one million people die in the world every year (World Health Organization, 2013).

Depression during pregnancy is a significant public health problem because it has negative effects that influence mother and child health. During antenatal visits, nurses and relatives of pregnant women give much more attention to physical health than mental/emotional well-being. This problem is both national and international. The prevalence rate of antenatal depression is even higher than postnatal depression. Globally, 12 % (range 8-51%) of all mothers suffer antenatal depression (Bennett, Einarson, Koren & Einarson (2004). According to one systemic review, the rate of antenatal depression is 10% in developed countries and 15% in developing countries. This meta-analysis also disclosed the prevalence rate of antenatal depression in the USA as 28.9% in 2011, England as 30.7% in 2010, in Australia as 28.3% in 2009, in Brazil as 9.0% in 2010 and, respectively in Nigeria as 8.3% in 2007 and in Thailand as 20.5% in 2006 (Pereira et al., 2011).

A community-based descriptive study from South Asia reported 25% of pregnant mothers to be suffering from antenatal depression (Rahaman, Iqbal, & Harrington, 2003). Among Bangladeshi women, the prevalence rate of antenatal

depression is 33% during gestational ages ranging between 34-35 weeks (Gausia, Fisher, Ali, & Oosthuizen, 2009). Hence, Bangladesh ranks the ninth for antenatal depression worldwide (Manikkam & Burn, 2012).

According to Manikkam and Burns, a 2012 report found 33% of Bangladeshi pregnant mothers to suffer antenatal depression, but the Bangladeshi government has always dealt with the mental health care system poorly. According to support of World Health Organization (WHO) United Nation Population Fund (UNFPA) Bangladesh government has taken initiative to fulfill MDG 4 and 5 to improve maternal and child health, in this program give more attention on physical health and very few in mental health (WHO, 2014).

1.1.2 Definition and clinical manifestation of antenatal depression

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013), depression is defined as:

A. Five (or more) of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms either 1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad, empty, hopeless) or observation made by others (e.g. appears tearful) . 2) Markedly diminished interest or pleasure in all or almost all, activities of the day, nearly (as indicated by either subjective account or observation). 3) Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% body weight in a month) or decrease or increase in appetite nearly every day. 4) Insomnia or hypersomnia nearly every day. 5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feeling or restless or being slowed down). 6) Fatigue or less of energy nearly every day. 7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick). 8) Diminished ability to think or concentrate or indecisiveness, nearly every day (either by subjective account or as observed by others). 9) Recurrent thoughts of death (not fear or dying) recurrent suicidal ideation without a specific plan or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The episode is not attributing to the physiological effects of a substance or to another medical condition.

Aforementioned symptoms that meet criteria of diagnosis depressive disorder was presented in pregnant women are considered antenatal depression.

1.1.3 Factors associated with antenatal depression

The exact cause of antenatal depression is unknown. However, according to research findings, following factors are risks for antenatal depression:

1.1.3.1 Demographic factors such as education represent one factor for antenatal depression whereby mothers with lower levels of education are at greater risk for depression (Yanikkerem, Ay, Mutlu & Goker, 2013). Previous history of mental illness is also a very important factor that plays a role in pregnant mothers suffering from depression (Nasreen, Kabir, Forsell & Edhborg, 2011 & Milgrom et al, 2007). Furthermore, family history of psychiatric illness also plays a great role in the development of depression during pregnancy (Humayun, Haider, Imran, Iqbal, & Humayun, 2012). In addition, previous miscarriage and multi-parity also play a significant role in antenatal depression (Cury & Menezes, 2012). Chronic medical conditions represent another strong predicting factor for depression during pregnancy whereby pregnant mothers suffering two or more medical conditions before pregnancy are more vulnerable to depression during a current pregnancy (Melville, Gavin, Guo, Fan & Katon, 2011).

1.1.3.2 Intrapersonal factors refers those which are one's own inner world, the strength to understand self and other people, to imagine plan and solve problem (Gardner, Armstrong, Campbell & Lazear, n.d.). Stressors are strong predicting antenatal depression because stress makes individuals more vulnerable to increased risk for subsequent depression. Intrapersonal factors are related to stress, namely, biological factors, psychological factors, fear of childbirth, emotion of pregnant women, stress related to several marital conflicts and unplanned pregnancy.

Biological factors: Mounting evidence from animal and human studies indicates that the hypothalamic-pituitary-adrenal (HPA) axis can become sensitized if

individuals are exposed to excessive stressors in early life. The aforementioned exposure leads to an increase in stress hormones in response to subsequent stressful life events. During pregnancy, stress may also heighten the secretion of the placental corticotrophin-releasing factor (Dayan et al., 2010).

Psychological stress means factors causing a person conflict in the performance of daily activities. Factors related to the current study include financial issues, family, friends, recent moves, recent losses, problems with work, substance use; current pregnancy and a feeling of being generally “overloaded” are all responsible for psychosocial stress contributing to depression in antenatal mothers (Gavin et al., 2011; Dayan et al., 2010).

Fear of childbirth is another issue causing depression because most women feel fear about the gender of the baby, the process of delivery and how health care providers will handle delivery, because pregnant mothers do not have much confidence in health care providers (Humayun et al., 2012). Another cross-sectional cohort study explains that stress related to fetal health is a strong factor contributing to antenatal depression. During pregnancy, mothers face anxiety about the health condition of the baby in their wombs, wondering whether or not the baby will have congenital abnormalities and any other complications after delivery; this stressful thinking leads to antenatal depression (Dayan et al., 2010).

Emotions of women fluctuate during the antenatal period, as hormones and environmental stressors also cause depressive symptoms (Milgrom et al., 2007).

Stress related to severe marital conflicts and serious difficulties at work also influence depression. If a mother is not happy in her marital life, she cannot give more attention on her work and has decreased interest in taking care of her baby (Dayan et al., 2010).

Unplanned pregnancy represents another significant factor in the etiology of depression, because mothers who are not mentally prepared for pregnancy cannot easily accept their babies. Consequently, these women become depressed and are at risk for antenatal depression (Yanikkerem et al., 2013). Another community-based study from Bangladesh found that unwanted pregnancies accounted for 1.4 more cases of antenatal depression than wanted pregnancies (Gausia et al., 2009).

1.1.3.3 Interpersonal Factors those are related with person with environment ([http:// www.merriam-webster.com/ dictionary/ interpersonal](http://www.merriam-webster.com/dictionary/interpersonal)). Interpersonal factors include the absence of social support. During pregnancy, emotional and behavioral changes occur in women's bodies and minds. Consequently, mothers expect proper support from husbands, mothers-in-law and other members of the family and society in order to overcome pregnancy-related depression (Yanikkerem et al., 2013). The following interpersonal factors are related to antenatal depression:

1) Husband-related factors

During pregnancy, a woman demands that her husband and other relatives take care of her. If she does not receive proper attention from her husband, this negligence is linked to the risk of developing antenatal depression. Moreover, it is crucial to psychological well-being during pregnancy. Factors such as no help received from husbands, domestic violence before and during pregnancy, and separation from husbands are all associated with antenatal depression. Husbands are valuable partners in the lives of women. If a husband fails to provide proper support and fails to maintain a good relationship with his wife, depression can also be the end result (Gausia et al., 2009). Domestic violence before and during pregnancy is common in developing countries, especially in Bangladesh where many pregnant women are beaten by their husbands for no good reason and sometimes beaten severely and repetitively (Gausia et al., 2009 & Melville et al., 2011). According to findings from a hospital-based cross-sectional study, separation from husbands is a predictor for antenatal depression, because pregnant mothers who do not receive support feel depressed in their own lives and in caring for their babies without physical, mental and financial support for their babies (Humayun et al., 2012).

2) Factors associated with mothers-in-law

Mothers-in-law play a great role in families and most family members obey their orders. Pregnant women reporting poor relationships with mothers-in-law or having an unhelpful/unsupportive mother-in-law were twice more likely to suffer depression than those reporting being on good terms with their mothers-in-law. One study from Jordan found that women's difficult relationships with mothers-in-law were associated with the development of antenatal and post-natal

depression. Most mothers-in-law in Jordan have a significant influence on their son's lives after marriage. Women are obligated to obey their mothers-in-law and respect them in order to maintain a good relationship with their husbands and live peaceful lives. The inability to address interpersonal family conflicts may, therefore, precipitate feelings of depression in some women (Mohammad, Mmid, Gamble & Creedy, 2010). According to the culture of Bangladesh, newly married women stay with husbands and extended family members. Some families have household matters controlled by mothers-in-law, while daughters-in-law remain under their control and carry out all household work according to her orders. In cases where mothers-in-law do not stay with daughters-in-law, but the orders of mothers-in-law also indirectly guide their daughters-in-law. Less contribution to household work during pregnancy also create conflicts with mothers-in-law and other family members of husbands. These conflicts also lead to depression (Gausia et al., 2009).

3) Culture-related factors Family or people in eastern cultures want children to be sons more than daughters in what is another common factor for antenatal depression in Asian countries. A community-based study in Bangladesh found women giving birth to daughters to be at 1.4 greater risks for depression than those who had no particular gender choice (Gausia et al., 2009). In the context of Bangladesh most of families want male baby rather than female, because people are thinking that when they get older this male baby will take care of than physically and financially. Female baby will not take of them, because after marriage they will go to husband house.

According to different database all above multifactor's are found that related with antenatal depression. All factors are found from developing and developed countries that are related with country context. In South –eastern Asia especially Bangladeshi pregnant women are suffering depression due to interpersonal factors.

1.4 Impacts of antenatal depression

Depression during pregnancy affects maternal functional status and causes cognitive distortions affecting maternal decision-making capacity with increased risk for substance use, adverse pregnancy outcomes, amplifies somatic symptoms of

pregnancy and psychosis, as well as self-injurious and impulsive behaviors (Manikkam & Burns, 2012). According to another descriptive study, the prevalence of medical disorders in antenatal depressive mothers is 7.1% for pre-eclampsia or chronic hypertension, 12.1% for cardiac disorders, 7.1% for diabetic's mellitus, 6.3% for maternal anemia, 8.3% for collagenosis and 12.55% for premature delivery (Benute et al., 2010). A meta-analysis by Marcus and Heringhausen in 2009 found untreated depression during pregnancy to lead to suicide. Intra-uterine Growth Retardation (IUGR) is one negative consequence of pregnancy outcome, because depressive mothers are not interested in consuming food leading to low weight gain. Negative outcomes were also associated with antenatal depressive mothers and birth outcomes such as pre-eclampsia, low birth weight, smaller head circumferences, increased risk of premature delivery, increased surgical delivery interventions, lower APGAR scores and more admissions to the neonatal intensive care unit. This meta-analysis also give explanation that the risk of long-term effects on the infant such as poor mother-infant attachment, delayed cognitive and linguistic skills, impaired emotional development and behavioral issues exist if depression continues until the postpartum period. Research articles have also described that these babies are fussier, vocalize their needs less and make less positive facial expressions than babies of those mothers who have no depression. If a baby lives in a depressed maternal environment during the first four months, delay the child's developmental progress and symptoms remain even if the depressed mother subsequently receives treatment. As these children grow, perhaps due to early contact or the continued stressful home environment, they are at greater risk for emotional instability, conduct disorders and attempted suicide with requirements for mental health services themselves.

Manikkam and Burns (2012) also showed antenatal depression to be associated with adverse fetal, obstetrical and neonatal outcomes, including intrauterine growth retardation (IUGR), low birth weight, preterm labor and infant behavioral problems. After delivery, women may exhibit depression-like behaviors such as fewer expressions of interest, excessive crying and inferior excitability prior to substantial mother-baby interactions.

Overall antenatal depression is a strong predicting factor for postnatal depression as found in two Randomized control trial (RCTs) (Spinelli & Endicott, 2003; Grote, Swartz, Geibel, Zuckoff, & Houck, 2009).

1.1.5 Therapy for depressive symptoms among antenatal mothers

From RCTs and meta-analysis, the literature review found that the following therapy can be used to reduce antenatal depression:

1.1.5.1 Pharmacological Treatment: Antidepressants and SSRI (Selective Serotonin Reuptake Inhibitors) are one form of pharmacological treatment for depression during pregnancy. One retrospective cohort study found that 8.7% of mothers had taken some types of antidepressants during pregnancy and 6.2% of mothers had taken SSRI during pregnancy (Cooper, Willy, Pont, Ray, 2007). According to a systemic review, many women are not interested in taking antidepressants and SSRI. If Fluoxetine is taken during the third trimester of pregnancy, there is increased risk for fetal weight loss. Direct drug effects and withdrawal syndrome occur if antidepressants are taken at full term and delivery (Wisner, Gelenberg, Leonard, Zarin, & Frank, 2014). According to one literature review, there is increased risk for seizures, dehydration, excessive weight loss and hyperpyrexia when Fluoxetine and Paroxetine are used during pregnancy, (Kolko, Bogen, Perel, Levin & Wisner, 2005).

1.1.5.2 Supportive or non directive therapy Supportive or patient-centered psychotherapy is one where the patient expresses feelings and emotions while the therapist gives support, warmth and a positive attitude for expression of feelings (Smith, 1950). Two systemic reviews also offered the suggestion that supportive or non-directive therapy is also effective in managing antenatal depression (Lau, 2013; Dimidjian & Goodman, 2009).

1.1.5.3 Cognitive behavior Therapy (CBT) is a type of psychotherapy use for management of antenatal depression. The objectives of this therapy are to decrease symptoms by targeting symptoms and modifying negative patterns of thinking and behavior (Austin et al., 2007). According to research articles, this therapy is effective in reducing antenatal depression (Lau, 2013; Burns et al.,

2011). However, one meta- analysis indicates that interpersonal psychotherapy (IPT) offers better management for antenatal depression than cognitive behavior therapy (CBT) among pregnant mothers who are suffering antenatal depression with interpersonal problems. Nevertheless, another systemic review indicated that IPT is more effective than CBT for the management of antenatal depression (Mello, Mari, Bacaltchuk, Verdeli, &Neugebauer, 2005).

1.1.5.4 Interpersonal psychotherapy (IPT) is an evidence-based, short-term and focus-limited type of therapy for depression. In this therapy, therapists can understand bio-psychosocial signs of depression and also understand the contents of the presenting social and interpersonal stressors that cause antenatal depression. The main objectives of IPT are symptoms resolution, increased interpersonal functioning and social support. With IPT, the therapist gives attention to altering and also planning to try and promote interpersonal relationships or alter hope about the aforementioned relationships. There are five parts of IPT: assessment phase, initial phase, middle phase, concluding acute treatment and maintenance treatment (Robertson, Rushotn & Wurm , 2008).

a) Assessment Phase: An assessment phase where the therapist completes a standard clinical interview and makes decisions about whether or not the patient is a good candidate for IPT.

b) Initial Phase: This phase includes a number of specific tasks. In this session, the therapist first aims to create interpersonal formulation. In their hypothesis is why the patient is suffering from interpersonal problems and how to solve the problem by social support.

The main function of this process of IPT is to give more concentration to patient and therapist in terms of the following:

1. Recent relationships
2. Patient's recent problems in forming these relationships.

3. Provision of information according to related solutions for the problem area such as attachment style, communication style and patterns of interaction.

4. Meeting to set appropriate goals.

c. Middle Phase: In this phase, the therapist and patient identify one or more problems area using key IPT techniques after identifying specific problems during the assessment and initial phase. This is the phase where the therapist gathers more information regarding the problem(s). Both patient and therapist attempt to find solutions such as improving the patient's communication skills or modifying expectations regarding conflict. A suitable solution is selected and the patient also implements this solution in this session. In subsequent sessions, both therapist and patient refine solution(s) and apply as needed.

IPT Problem Areas: Four areas are included for better understanding of the patient:

1. Grief
2. Interpersonal disputes/role disputes
3. Role transitions
4. Interpersonal deficits (Interpersonal sensitivity).

d. concluding treatment: The main goals of the termination phase are a quicker return to the patient's functioning independently and increasing a sense competence. In IPT, the patient learns new communication skills and the therapist helps the patient develop new insight for communicating needs to others and helping establish greater skill in forming social networks and all services for improving social functioning.

e. Maintenance treatment: A new agreement is made for the maintenance phase when needed or when both patient and therapist want to continue.

IPT Techniques: IPT is based on micro-counseling and psychotherapy. The following techniques are applied during IPT:

1. Non-directive and directive exploration
2. Clarification
3. Encouragement of affect

4. Communication analysis
5. Role playing
6. Problem-solving

According to the literature review, antenatal depression is correlated with interpersonal factors such as relationships with their husbands and relationships with mothers-in-law. According to three systemic reviews (Mello et al., 2005; Dennis, Ross and Grigoriadis, 2007; Sockol, Epperson, barber, 2011), two literature reviews (Dimidjian and Goodman, 2009; Brandon and freeman, 2011) and one guideline (Choate and Gintner, 2011). IPT can effectively reduce antenatal depression. Therefore, the author is interested in analysis and synthesis of the evidence for reducing antenatal depression.

1.2 Clinical problem of the study

Upazilla Health Complex Gazaria, Munshigonj, is a fifty-bed hospital under the Ministry of Health and Family Welfare (MOFW). This hospital offers out-patient service for the most part and 100/200 patients are treated every day. The hospital also offers in-patient facilities that are primarily for the care of all emergency patients. Mental health is a challenging issue for people, but this hospital has no suitable in/out-patient unit in the mental health care system care for mentally ill patients. As a professional nurse working in the hospital's obstetrical care unit, the investigator has experience talking with pregnant mothers. When the author takes history from mothers, some of the pregnant mothers were found to not be interested in their babies or worried about their pregnancies, because most husbands and family members prefer male babies. Another big issue also contributing to depressive symptoms in pregnant mothers is an absence of support from husbands and mothers-in-law. Most pregnant mothers came for antenatal visits with members of the women's parents' families. Pregnant mothers also have stress about how to handle labor and who will oversee delivery. When the mothers talked with the author, most explained previous bad experiences with delivery or others described relatives' deliveries with complications. Unplanned pregnancy is also a challenging issue and two to three mothers come for abortions every day, because they have limited knowledge about

contraception. Some pregnant women have unwanted pregnancies and some husbands' family members do not the baby. Hence, they suggest abortion. The signs and symptoms of the mothers did not indicate interest in babies. Rather, the indication was confusion, guilt and an inability to feel happy about the pregnancy. Regardless, the author feels there is no option available to check the pregnant mothers' mental health status or depression. Nevertheless, this issue is very huge because these consequences affect both mother and child. Therefore, the author as a psychiatric nurse realizes this problem deeply and is interested in developing a nursing practice guideline for using interpersonal psychotherapy in order to reduce antenatal depression based on research evidence.

1.3 Purpose of the study

To analyze and synthesize the evidence related to interpersonal psychotherapy to reduce antenatal depression among pregnant women.

1.4 Expected benefits of the study

1. The hospital in Bangladesh will use the recommendations from this paper to develop clinical practice guidelines to reduce depressive symptoms in antenatal women in Bangladesh.
2. Women who have depressive symptoms and their family members will be benefited by participating in interpersonal psychotherapy to reduce depression symptoms in Bangladesh.

CHAPTER II

METHODOLOGY

2.1 Search strategy

In order to find out the effectiveness of IPT in nursing care practice toward reducing the depression of antenatal mothers, the author applied the PICO framework as recommended by Melnyk & Fineout-Overholt (2011), as the search strategy for solving the problem. Evidence-based practice was sought from databases with evaluation of the quality and strength of the evidence. A thorough explanation of study method followed in this study is presented below:

2.1.1 Search framework

The author searched and selected evidence-based practice for antenatal interpersonal psychotherapy to reduce depressive symptoms in antenatal mothers by using the PICO Framework (Melnyk & Fineout-Overholt, 2011) with the following details:

P (Population)=antenatal mother/Pregnant women/Prenatal mother

I (Intervention)= interpersonal psychotherapy

C (Comparison) =usual activity

O (Outcome)=antenatal depression/depressive symptoms

2.1.2 Scope of the search

2.1.2.1 Keywords

Keywords were set for the search criteria as follows:

P= antenatal mothers

I= interpersonal psychotherapy

C= usual activities

O= antenatal depression.

The author used a Boolean operator to conduct the search. For each PICO element, the author collected synonyms by connecting terms with “OR” then locating citations relevant to all PICO elements by linking with “AND”.

2.1.2.2 Specifying the evidence criteria

- 1) Research studies using interpersonal psychotherapy to reduce depressive symptoms in antenatal mothers.
- 2) Research studies that were systemic reviews, meta-analyses, randomized controlled trails, quasi-experimental studies and one-group pretest-posttest design studies.
- 3) Completed research studies published in English from 2003 to 2014.

2.1.2.3 Databases/sources used for the search

The author used Mahidol University Library for manual searching and electronic data bases, including the Cochrane Database for a systematic review. In addition, the author also used Cumulative Index to Nursing and Allied Health (CINAHL), Ovid Full Text, ProQuest nursing, PubMed, Science Direct, and Springer Link to search for single research studies.

2.2 Appraisal method and levels of evidence

2.2.1 Evaluation of quality of research-based evidence

The author evaluated the quality of the evidence, according to the following three questions by Melnyk & Fineout-Overholt (2011): 1) Are the research findings valid? (Validity) 2) what are the findings? (Reliability) and 3) Will the findings help the investigator in caring for patients? (Applicability). These three questions are briefly described below:

1) Are the research findings valid? (Validity)

The validity of a research articles refers to whether or not the findings are obtained by clear research methodology. Bias and extraneous variables are two factors that interfere with validity. The findings of any article will be more valid if those factors have less influence on the study.

Bias is one of the factors that hamper research in continuing with a systemic method and this also arises in research methodology. Every study requires careful examination in order to discover any factors influencing bias in the study. During the course of the study, every stage may be subject to bias such as selection bias in choosing a population to be included in the study. This bias can be minimized by randomly assigning a population in the control and experimental groups. Another bias in RCTs occurs when the participant or researcher knows which subjects belong to the control group and which belong to the experimental group. To reduce this bias and maintain the anonymity of the participants concerning assignment to the experimental and control groups, this type of research is called a “double blind study”. Measurement bias is another type that also influences research in terms of systemic errors when results are higher or lower from actual findings. When the experimental group is exposed to the control group and information is exchanged between the experimental and control groups during intervention, the situation is called contamination bias which also affects validity.

Research findings are confounded when another factor influences both the intervention and outcome, but is not directly a part of the relationship between the two. Randomized study designs are the best way to minimize the potential impact of extraneous variables because the process of extraneous known or unknown variables has equal influence over the outcomes of both groups.

2) What are the findings? (Reliability)

The main theme of reliability provides an explanation about the effects of intervention with attention given to calculating the effects not only sheds light on the research findings, but also evaluates when applied in the researcher’s own clinical area of practice where the same findings can be discovered.

In all research, reporting the research findings clearly reveals how the size of the population finally selected, as well as who was selected for the control and experimental groups. In the section on the findings, another test provides an explanation about the number of participants and the outcome of the intervention. Also provided is the attrition rate for participants during follow-up with the reasons for drop-outs.

The magnitude of the effects refers to determining the degree of variance or scope of the differences among various groups. Two-by-two tables can also be used to easily understand the magnitude of effect. In statistical testing, these tables are used for determining significant differences between two groups.

3) Will the research findings help the investigator in caring for patients? (Applicability)

The last question concerns applicability, which means implementing an intervention with an individual or local situation. Context or any harm can affect patients following application of this intervention.

2.2.2 Evaluating strength of evidence

The strength of evidence is evaluated according to the hierarchy of evidence-based practice by Melnyk & Fineout-Overholt (2011).

Level I Evidence from a systemic review or meta-analysis of all relevant RCTs

Level II Evidence obtained from well-designed RCTs

Level III Evidence from well-designed controlled trials without randomization

Level IV Evidence obtained well-designed case-control and cohort studies

Level V Evidence from systemic reviews of descriptive and qualitative studies

Level VI Evidence from single descriptive or qualitative studies

Level VII Evidence from the opinions of authorities and/or reports from expert committees

Summary: In order to fulfill the objectives of the study, the author searched by using the PICO format, which is a highly effective method for determining the target population, intervention and outcome related to the study. The Mahidol University electronic database was used to find articles from which evidence-based practice was eventually selected after evaluating the quality of the evidence in terms of validity, reliability, applicability and strength of evidence. The author's search yielded 57 articles related to the study. Finally, 5 articles were selected for the

study, all of which met the appraisal criteria Two articles were obtained from PubMed, two from ProQuest Nursing and one from Science Direct. The author searched for high quality evidence acquired from full text studies published in English from 2003 to 2014.



CHAPTER III

FINDINGS

3.1 Searching result

According to clinical problem, the author finally selected articles that are related to current study by PICO format. The author used electronic database of Mahidol University to collect systematic review, high qualities randomized control trail, Quasai-experimental and Pretest-posttest design. In below, the author elaborated the articles and mentioned the level of strength:

Table 3.1 Selected evidences, research design and strength of the evidences

Order	Author, year, title& source of publication	Research design	Strength of evidence
1.	Spinelli, G. M., Endicott, J. (2003). Controlled clinical trial of interpersonal psychotherapy versus parenting education program for depressed pregnant women. <i>American Journal of psychiatry</i> , 160, 555-562.	RCT(Randomized control trail)	Level-2
2.	Grote, K. N., Swartz, A. H., Geibel, L. S., Zuckoff, A., Houck, R, P., & Frank,E. (2009). A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression. <i>Psychiatric Services</i> ,60(3).	RCT	Level-2
3.	Leung, S.K,S.&Lam,T.H.(2012). Group antenatal intervention to reduce perinatal stress and depressive symptoms related to intergenerational conflicts: A randomized controlled trail. <i>International journal of nursing Studies</i> 49, 1391-1402.	RCT	Level-2

Table 3.1 Selected evidences, research design and strength of the evidences (cont.)

Order	Author, year, title & source of publication	Research design	Strength of evidence
4.	Field, T., Diego, M., Delgado, J., & Medina, L. (2013). Peer support and interpersonal Psychotherapy groups experienced decreased prenatal depression, anxiety and cortisol. <i>Early Human Development</i> 89, 621-624.	Quasi-experimental	Level-3
5.	Brandon, A., Ceccotti, N., Hynan, S. L., Shivahumar, G., Johnson, N. & Jarrett, B. R. (2012). Proof of concept: partner-Assisted interpersonal psychotherapy for perinatal depression. <i>Archives women's mental health</i> , 15, 469-480. doi 10.1007/s00737-012-0311-1.	Pretest-posttest design.	Level- 4

3.1.1 Summarized of five articles

Article number 1

Title: Controlled clinical trial of interpersonal psychotherapy versus parenting education program for depressed pregnant women.

Authors: Spinelli, G. M., Endicott, J.

Publication source and year: American Journal of Psychiatry (2003).

Objectives

1) To determine the efficacy of interpersonal psychotherapy versus a parenting education program for unipolar depressed no psychotic pregnant women, and

2) To test the feasibility of a placebo-controlled bilingual clinical treatment trial in an ethnically and economically diverse population of pregnant depressed women.

Method

Design: Randomized control Trails (RCTs).

Sampling

Fifty outpatient antenatal women who met DSM-IV criteria for major depressive disorder were randomly assigned to interpersonal psychotherapy or didactic parenting education program.

- 1) 25 patients were randomly assigned for experimental interpersonal psychotherapy group
- 2) 25 patients were randomly assigned for control parenting education group.
- 3) For data analysis includes 38 women who had completed at least one interpersonal psychotherapy.

Inclusion Criteria

- 1) English and Spanish speaking, physically healthy pregnant women between 6 and 36 weeks pregnancy.
- 2) Age between 18-45 years.
- 3) Met DSM-IV criteria for major depressive disorder according to HDRS score ≥ 12 .

Exclusion Criteria

1. Drug or alcohol abuse before 6 month.
2. Acute risk for suicide
3. Currently taking antidepressant
4. Comorbid axis I disorders or medical conditions.

Setting: Hospital-based study

Measurement: 1) The Edinburgh Postnatal Depression Scale 2) Beck Depression Scale 3) Hamilton Depression Rating Scale & The Clinical Global Impression.

- 1) The Edinburgh Postnatal Depression Scale is give more attention on behavioral changes, did not more attention on somatic change. This measurement is preliminary designed for postpartum mood state and also use to measure sensitive in pregnancy and in this study advantage that ,this measuring scale is translated in Spanish .The Edinburgh Postnatal Depression is only one self-reported mood measuring scale validated for use in pregnancy and post-natal period (sensitivity=86%, specificity=78%).

2) The Beck Depression inventory is a self-rated measurement scale used for measurement of depressive symptoms in both the general and puerperal population. The beck depression inventory scaling the cognitive–affective cluster of depression during pregnancy. This measuring scale give more important to measure reduce the somatic changes.

3) The Hamilton scale also use for measure somatic symptoms such as appetite and weight changes during pregnancy

4) The clinical global Impression also use for measurement of severity and improvement of depression.

Intervention

Experimental group received interpersonal psychotherapy:

Interpersonal psychotherapy according to the manual by Klerman et al.(1984) modified to antenatal depression. Original interpersonal covers four areas like, grief, interpersonal role disputes, role transitions and interpersonal deficits. But in antenatal depression need to broad fifth area, complicated pregnancy, addresses problems such as undesired/unintended pregnancy, medical problems associated with pregnancy itself, obstetrical complications, multiple births and congenital anomalies. The participants met for 45 minutes weekly sessions over 16 weeks with therapist.

Therapist

Two experienced therapists (with an M.D and a C.S.W) are receiving one year interpersonal psychotherapy supervision. Their training included modification of their training skill regarding interpersonal psychotherapy to arrange a unique method of procedure and also psychotherapy management.

Control group received Parenting education The parenting education program is a systemic educational program, weekly educational sessions. The patients are assigned by therapist and seen every after 7 days and make 45 minutes sessions and their symptoms and what action they had during this period. As like interpersonal psychotherapy duration of period was 16 weeks.

At the time of parenting dedicating sessions, the therapist give much more attention on the development of pregnancy, parturition, taking child care and maintain baby first year of life. The main difference in this stage that parenting education

program give more attention on taking care of her and also taking care of baby, but interpersonal psychotherapy give more attention to development emotional support.

Training in Parenting Education

The supervisor provided written instruction, book related pregnancy, the postpartum period, taking care of early childhood , and also arranged videotape and aids that make sense how to development stages of pregnancy, parturition and also taking care of newborn baby.

Data Analysis

Paired t test was applying both groups for measure outcome of intervention, before and after use this therapy. The efficacy of this two therapy was measure by comparing depressive symptoms score by measuring scale like, the Hamilton depression scale, the Beck Depression inventory, the Edinburg postnatal depression Scale by using intent – to- analysis and also last phase carried for last score. For more confirmed result repeated various analysis model uses for two groups. Contingency table used chi-square test also defined score of ≤ 6 on Hamilton depression scale. Pearson's correlation Coefficients are also used for compares on Hamilton depression Scale. All statistical tests were two-tailed and also alpha level 0.05.

Result

Interpersonal psychotherapy demonstrated significant advantage over parenting education for all mood scores, while both groups showed improvement over the course of treatment.

The difference in the recovery rate on the interpersonal psychotherapy 60.0%, compared to the 15.4% rate of the parenting education control group.

Article number 2

Title: A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression.

Authors: Grote, K. N., Swartz, A. H., Geibel, L. S., Zuckoff, A., Houck, R. P., & Frank, E.

Publication source and year: Psychiatric Services (2009).

Objectives: The objectives was to examine the treatment with enhanced brief interpersonal psychotherapy would result in significant improvement in psychotherapy and functioning during pregnancy and at the six months postpartum, compared with enhanced usual care.

Method

Design: Randomized control Trails (RCTs)

Sampling

Fifty-three non-treatment –seeking ,pregnant African-American and white patients receiving prenatal services in a large , urban obstetrics and gynecology clinic and meeting criteria for depression on the clinic.

1. Age 18years or older
2. 10 to 32 week's gestation.
3. Cutoff score > 12 on the Edinburg postnatal depression measuring scale
4. English speaking access to a telephone
5. Participant also live in Pittsburg region

Exclusion Criteria

1. Substance abuse or dependence before 6 month
2. Actively suicide
3. Bipolar disorder
4. Psychiatric disorder
5. An organic mental disorder
6. Unstable medical condition (untreated thyroid disease)
7. Severe intimate partner violence
8. Current receipt of another form of depression treatment.

Setting: Hospital based-study (Perinatal service in large hospital).

Measurement

The Edinburg Postnatal Depression scale (EPDS):10- Item scale was use for study eligibility (with a cutoff score of >12) and measure outcome.

Intervention

Cultural relevant, enhanced brief interpersonal psychotherapy (IPT-B) was use in experimental Group: Enhanced IPT-B is consisting of various components of sessions, engagement session, acute IPT-B, and maintenance IPT.

Engagement session is based on principles of motivational interviewing and ethnographic interviewing. Its designed is early make rapport for building trust and also give more emphasis on practical, psychological and cultural barrier to care experienced by individual who are socioeconomically deprived.

During engagement session each participant explores their own problem and engages joint problem solving to restructure each obstacle. In addition, during interviewer approaches the participant in a culturally relevant manner with the principles of ethnographic interviewing. The role of interviewer as a learner, tries to understand cultural relevant perception and standards of women without any bias, asked question idea about depression, idea about health and how to cope with any situation and also asked about that she want to accompany of therapist.

IPT-B alike to IPT is made for reduce depression by assisting patient with four domain of interpersonal areas (role transition, role dispute, grief and interpersonal deficits) connected with beginning depression or protection of a depressive period. However it is vary from IPT number of ways. For example, to decrease treatment burden and work change of participant, session reduce from 16 to 8.

Additional IPT-B was arranged to have biweekly or monthly continuation IPT sessions to 6 month postpartum for avoid depression recurrent by assisting participant contact with community and family related with reduction.

In enhanced IPT-B reflected seven component from eight component of culturally centered framework eg; persons, metaphors, concepts, content, goals, methods and contexts. They appointed therapists whom were trained in cultural knowledge and had huge experience about with person with racial-ethnic small group who are live under poverty. They also use the elements of metaphors by show culturally related pictures of racially and ethnically diverse infant picture at therapist office and also using stories from participant that are culturally related for purpose of treatment goal. For identify the component of concept , therapist arrange educational about depression that the participant accept by her cultural and also they use

“depressed” in here as “stressed” if the participant want ,so this use for reduce social stigma. Then the component, content was identify by extension what coping mechanism and cultural resources such as religious or familismo, had helped participant this resource to build up new coping skill during treatment. Therapist assist participant to new coping skill that were cultural relevant. Method was outreach and short period of treatment that were not make burden for participant.

Usual care

For usual care participant also arrange same facilities like IPT-B group for overcome barrier and also easy available depression management and try to familiar with clinic for reduce shyness, knowledge regarding child care, and also free bus service. Mother with usual care accept more look after according to level of depression. As a research communication with them every three week and their mood and also promote them to therapy, as direction.

Data analysis: The Edinburg post- natal depression measuring scale is used for before delivery, three month after delivery and at six month after delivery for measuring level of depression after intervention/ usual care of both groups.

Results

From that study found that culturally relevant, brief interpersonal psychotherapy reduce depression during pregnancy and up to six month of postpartum compared to usual care. The mixed- effects models using maximum likelihood procedures were employed to conduct intent-to-treat analyses to assess change in clinical and functioning variable from baseline to time 2 and time 3

The results revealed Changes in depression diagnostic status and depressive symptoms as follows

Before Childbirth, chi-square analyses showed that a significant larger proportion of women in the intervention group (N=21 of 22,95%) , compared with those in usual care (N=15 of 26 58%), with a large effect size ($X = 9.06$, $df = 1$, $p < .003$; cohen’s $h = .96$). Similarly, at time 3 analyses revealed that none of women assigned IPT-B had major depression, compared with 70% of those in usual care (N=16 of 23), with a very large effect size ($\chi^2 = 7.92$, $df = 1$, $p < .005$; Cohen’s $h = 1.22$). Further, with respect to 50% improvement on the EPDS, chi square analyses showed that at time 2 (before childbirth), 80% (N=20 of 25) of the intervention group responded to

treatment, compare with 29% (N=8 of 28) of the usual care group, with a large effect size ($\chi^2=14.02$, $df=1$, $p<.001$; Cohen's $h=1.08$). Six months postpartum, 88% (N=22 of 25) of women in IPT-B responded to treatment, compared with 25% (N=7 of 28) of those in usual care, with a large effect size ($\chi^2=21.16$, $df=1$, $p<.001$; Cohen's $s=1.17$).

b. Change in clinical functioning symptom scores

From the pattern of findings indicate that symptoms of depression significantly improve more treatment group more than usual care group between baseline and 2, 3 times. Overall treatment satisfaction was quite high (mean =+ SD=4.4=+39; 1-5 rating scale).

Article number 3

Title: Group antenatal intervention to reduce perinatal stress and depressive symptoms related to intergenerational conflicts: A randomized controlled trail.

Authors: Leung, S.K, S. & Lam, T. H.

Publication source and year: International journal of Nursing Studies (2012).

Objectives: To examine the effectiveness of an interpersonal psychotherapy oriented group intervention to reduce stress and depressive symptoms in new mothers and enhance happiness and self-efficacy in managing intergenerational conflict in childcare.

Method

Design: Randomized control Trail (RCT).

Sample: 156 pregnant women were including for study. 78 pregnant women were in the intervention group and 78 pregnant women were in the control group.

Inclusion Criteria

1. 18 years old or above
2. 14-32 weeks gestation
3. Hong-Kong residents
4. Able to communicate in spoken and written Chinese

5. parent-in-law living in Hong-Kong

Exclusion Criteria

1. Have mental illness
2. Previous have mental illness

Setting: Hospital based study

Intervention: For experimental Group was received Group antenatal intervention

This intervention was intention to taken care of pregnant mother with interpersonal issues with intergenerational conflicts. Before intervention done careful assessment for acceptance of therapy. The intervention was make format and also had option for feedback from participants 12 target groups of pregnant and postnatal and as well as grandparents. The therapy content and manual were developed by the 1st author and also include team a clinical psychologist and also two senior medical officers. The intervention made monthly and time for each session 1.5 hours.

Use way to encourage participant's by follow a group community based family centered Program, This program provided-

1. Use of short video clip to stimulate discussion
2. Participant identification of errors and development of alternative strategies.
3. Role-play
4. Weekly homework for practice

Take four week distention for that participant can clearly understand and also done clearly home work. After completed each session gave homework assignments for practice the skills or behaviors in the session. When participant meet next session give opinion about her problem and therapist arrange way for peer support and also solve this problem.

Session I: Give more concentration that participant make a good relationship with grandparents, who will take care of baby and also review current problem that make stress and depression.

Session II: Find out the sequences of poor and appropriate communications, set a plan for how to make relationship and also make partner developmental skill for take care of child.

Session III: Discuss area of interpersonal problem like role transitions and disputes and demonstration role play and also practiced specific communication and management skills as such good listening, find out goal and positive expression in non-threatening ways.

Session IV: In this last session discuss how to emotion control and discuss importance of control of emotion, which are more comfortable than external environment and another response of interaction.

The control group was received normal routine antenatal care, physical examination were done by midwives and during this time take brief interview, gave answer which participants wanted to know.

Measurement: The 10-item Edinburg post-natal depression was used for measure the level of depressive symptoms before and after delivery.

Data analysis: 2-tailed t tests are used for continuous data and X² statistics and 2-tailed Fisher exact tests for categorical test. Primary outcomes are measured by ANOVA test.

Results: Depressive symptoms and depression also likely change in both groups as like stress. After intervention when level of Treatment 2 and Treatment 3 decreased on intervention group and control group report that increased depression level, but the differences between groups were not significant at both time points.

Article number 4

Title: Peer support and interpersonal psychotherapy groups experienced decreased prenatal depression, anxiety and cortisol.

Authors: Field, T., Diego, M., Delgado, J., & Medina, L.

Publication source and year: Early Human Development (2013).

Objectives: The purpose of the present study was to compare the effects of participating in peer support versus interpersonal psychotherapy groups on prenatal depression.

Method

Design: Quasi- experimental Study

Sampling: Forty –four prenatally depressed women were randomly assigned to peer support (n=22) or interpersonal psychotherapy groups (n=22).

Criteria for recruitment were

1. Age = 18 to 40 years at 22-24 weeks gestation (m=22weeks).
2. Being depressed, as diagnosed on the structured Clinical Interview for Depression (SCID)
3. Being pregnant with one child
4. Having an uncomplicated pregnancy with no medical illness
5. No drug history (i.e., prescribed or illicit)

Setting: Hospital- based study

Intervention

Peer support for control group

The women in the peer support group participated 20- minutes session once a week for 12 weeks. During this sessions participated are engagement with decision different types of topic. One staff was present, but she was trained and her role was silent.

Interpersonal psychotherapy for experimental group

The interpersonal psychotherapy group sessions were arranged one hour per week for 12 weeks. The main theme was pregnancy experience and relationship with problems. The curriculum was developed by comprehensive guideline for interpersonal psychotherapy. In intrapersonal psychotherapy the therapist was active during intervention. They use specific techniques for explanation, encouragement of affect, clarification, communication analysis and use behavior change technique.

Training to be therapist

Before applying therapy, therapist gained knowledge and training for interpersonal psychotherapy and during applying therapy, another therapist supervise her activities.

Data analysis: Repeated measures by group ANOVA were conducted with the repeated measures being pre-to post session on the first and last days on the study and Hedge's were determined for effect size.

Results: From this study found that group interpersonal psychotherapy is more effective for reduce depressive symptoms than peer group.

After implementation of therapy found that significant change in both group, as below:

Both groups had significant changed as follows

- 1) Decreased depression from the first to the last days ($F= 7.04, p<.005, g=2.05$)
- 2) Decreased anxiety from the first to the last days ($F= 5.91, p<.01, g=1.78$)
- 3) Lower cortisol levels after the last day session, although the decrease was greater for the peer support group ($f= 6.93, p<.001, g=1.98$)

Article number 5

Title: Proof of concept: Partner –Assisted interpersonal Psychotherapy for perinatal depression.

Authors: Brandon, A., Ceccotti, N., Hynan, S. L., Shivahumar, G., Johnson, N. & Jarrett, B. R.

Publication source and year: Archives women's mental health (2012)

Objectives: The aims of this “proof of concept” study was to test safety, acceptability, and feasibility of partner-assisted interpersonal psychotherapy (PA-IPT), an intervention that includes the partner as an active participant throughout treatment.

Method

Design: Pretest-Posttest design.

Sample: 11 women who met full criteria for major depressive disorder and it her moderate symptoms severity (HAM-D 17 score was >16) and her partner.

Inclusion Criteria

1. Age 18years or older
2. Gestation age 12 weeks or less than 12 weeks postpartum
3. Married or live together with their partner for a minimum of 6 months.
4. Not taking any psychiatric medication or on a stable regimen (more than 4 weeks)
5. English speaking

Exclusion Criteria

1. Substance abuse/dependence
2. Cognitive disorder or Schizophrenia
3. Presence of psychotic or manic symptoms
4. Endorsed partner violence
5. Partner with psychiatric illness
6. Treatment with psychotherapy/psychopharmacological treatment.

Setting: Hospital- based study.

Measuring scale: The Hamilton Rating Scale for Depression (HAM-D) 17 items used for measuring patient major depressive disorder. The revised 17-item version is the famously used for the outcome of intervention for MDD and this scale used for measuring antenatal depression

The EPDS developed ideally for identifying post-natal depression but this measuring also used for identifying post-partum depression. Total score on these ten-items, multiple choices from 0 to 30, high score indicate severity of depression.

Intervention

Partner-assisted interpersonal psychotherapy was consist three phases and bear out over eight sessions. The first phase of PA-IPT is characterized by accessing the depressive experience from the perspectives of both partners, eliciting how they each understand the events or stressors that may have occurred prior to the onset of her depression and any associations they may have made between a “trigger” and the symptoms. The middle phase of treatment aims to explore the role expectations each partner has of self and other, and interaction between them that are perceived as supportive or conversely, unsupportive. The final phase consolidates changes, explores additional sources of support, and processes what the experience of therapy has been like for each partner.

To show their support system, every partner finished the IPT” Circle of Closeness” identifying in three concentric circles those individuals in their social environment according to level of closeness. The circle of closeness is occasionally utilized as a point of reference, helping recognize which family or friends may be able to fill up gaps of help that remain or are likely to occur at after points in the shift of new role. Communication identify around goal event or impotency linked and the

therapist arrange role-plays for show new ways of questioning for help. In last session alternative ways are explained for both their possible effect and their approximately repeated.

Data analysis

The Hamilton depressive measuring scale, The Edinburg postnatal depression measuring scale and The Dyadic Adjustment scale is used for measuring depression before and after intervention. Two – way analysis of variance (ANOVA) is done factors are person are related with intervention.

Results: From this study found significance differences in depressive symptoms after session eight and at the 6 weeks follow-up. Women had high levels of depression before intervention (19.11 ± 6.13) that gradually decreased by session eight (6.00 ± 4.47) and also still low at the 6- week follow-up evaluation (5.89 ± 2.37) except one woman did not reduce their symptoms significantly.

Summary of evidences appraisal: Five research evidences aforementioned were critically appraised for their validity, reliability and applicability using the criteria of Melnyk and Fineout-Overholt (2011) as stated in chapter 2. The author confirmed the accuracy of her appraisal with the major advisor and co-advisor. The result of the appraisal revealed that all evidences were conducted in scientific procedure. The results of each research were relevant with the clinical issues of this study and can be applied in the author's clinical setting.

Table 3.2 Collective tables of five articles

Article	Article number 1	Article number 2	Article number 3	Article number 4	Article number 5
<p>Research Methodology</p>	<p>treatment trial in an ethnically and economically diverse population of pregnant depressed women</p> <p>RCT</p>	<p>RCT</p>	<p>RCT</p>	<p>Quasi-experimental</p>	<p>Pretest-posttest design</p>
<p>Characteristics of sample</p>	<p>- 18-45 years of age.</p> <p>-6-36weeks gestation.</p> <p>-Met DSM-IV criteria for major depressive disorder.</p> <p>-Socio-</p>	<p>-18yeras- older</p> <p>-10-32 weeks gestation</p> <p>- Low – income.</p>	<p>-18 years- above</p> <p>- 14-32 weeks gestation.</p>	<p>- <40years old</p> <p>-20-24weeks pregnancy (M=22 weeks).</p>	<p>-18 years-older</p> <p>- 12 weeks gestational age.</p> <p>-DSM-IV criteria for Major Depressive Disorder and reported moderate symptoms severity (HAM-D≥16).</p>

Table 3.2 Collective tables of five articles (cont.)

Article	Article number 1	Article number 2	Article number 3	Article number 4	Article number 5
	economically deprived women.				
Level of depression	HDRS score ≥ 12 .	EPDS score ≥ 12 .	EPDS score ≥ 12 .	-Diagnosis of depression on SCID scale.	HDRS score ≥ 16 .
Setting	Hospital (Out Patient Department).	Hospital (Outpatient of obstetrics and gynecology clinic)	Hospital (Maternal and Child Health care Centers).	Hospital(Clinics)	Hospital (Women's Mental Health Center).
Intervention	IPT	Cultural relevant , Brief interpersonal psychotherapy(IPT-B) followed by maintenance IPT	Group antenatal intervention is following the guideline of IPT	IPT	Partner –Assisted IPT
Outcome	Depression, anxiety and parenting difficulties	Depression	Anxiety and depression	Depression , anxiety and cortisol	Depression

Table 3.2 Collective tables of five articles (cont.)

Article	Article number 1	Article number 2	Article number 3	Article number 4	Article number 5
Type of IPT (Group or individual IPT)	Individual IPT	Individual IPT	Group IPT target in managing intergenerational conflict in childcare.	Group IPT	Partner –Assistance IPT
Length of session and length of therapy	16 weeks and 45minutes per session, per week.	8weeks	4weeks and 1.5 hours per session.	12 weeks and one hour per session, per week.	8 weeks, per week.
Component of therapy	1. Four area of IPT(Grief, role transition, dispute, conflict) 2) Added one area, discuss about pregnancy.	1)Engagement session 2)Acute IPT-B 3) Maintenance IPT, followed by Multi-component Model of care.	1) Motivation of participants 2) Good Communication 3)Discussion about problem 4) Solution of problem.		1) Assessment phase 1)Treatment phase 3) Consolidates phase.

Table 3.2 Collective tables of five articles (cont.)

Article	Article number 1	Article number 2	Article number 3	Article number 4	Article number 5
Material	1) Manual of IPT, followed by Klerman et al. (1984).	1. Educational material regarding depression	1 IPT is consisted according to followed Interpersonal Theories of Sullivan, 1953.	1. Comprehensive Guideline to Interpersonal psychotherapy, according to followed attachment theory.	Manual of interpersonal psychotherapy
Techniques		- Exploratory -encouragement of affect -clarification -Communication analysis -Behavior change	1) The use of short video clip for encourage discussion 2) Participant identify problem and also find out alternative solution. 3) Role play 4) Home work.	Exploratory -encouragement of affect -clarification -Communication analysis -Behavior change	1) Circle of Closeness, consist of three phase: a) Find out family member or friend for support b) Communication analysis : role play c) Alteration of communication.

Table 3.2 Collective tables of five articles (cont.)

Article	Article number 1	Article number 2	Article number 3	Article number 4	Article number 5
Measurement of depression: 1.)The Edinburgh postnatal depression scale	✓	✓	✓	✓	✓
2) The Beck Depression Scale	✓	✓			
3)The Hamilton Depression Rating Scale	✓				✓
4)The Clinical Global Impression	✓				
5) Diagnosis of depression on SCID scale.	✓			✓	

Remarks:

HDRS= Hamilton Rating Scale for Depression.

EPDS= Edinburgh Postnatal Depression Scale.

SCID=Structural clinical Interview Depression

3.2 Recommendations

After analysis and synthesis of the five articles, the author was able to draw conclusions for recommendations on how to use interpersonal psychotherapy (IPT) to effectively reduce antenatal depression. The model for using IPT to reduce antenatal depression can be classified into two main types, including IPT for women meet criteria of MDD and IPT for women with mild to moderate depression. According to the research articles, the author was able to classify the pregnant women into two groups, including pregnant women who met the criteria for MDD diagnosis and pregnant women who have mild to moderate levels of depressive symptoms and do not meet the criteria for MDD diagnosis. Therefore, IPT for women meet criteria of MDD (16 weeks of group sessions) (Spinelli& Endicott, 2003: Level II) is suitable for pregnant women who meet the criteria for MDD diagnosis. Moreover, there are two types of IPT, group IPT (12 weeks of group sessions) (Field, Diego, Delgado & Medina, 2013: Level III) and partner assisted IPT (a couple of sessions per week for 8 weeks of sessions) (Brandon et al., 2012: Level IV) also effectively reduced antenatal depression in women who met the criteria for diagnosis. However, the results came from a lower level of evidence. Hence, the author also added some content as needed for the recommendations in this model. Another IPT for women with mild to moderate depression is suitable for pregnant women who have mild to moderate level of depressive symptoms and do not meet the criteria for MDD diagnosis. However, there is a type of group antenatal intervention that adds issues related to managing intergenerational conflicts in childcare that can reduce depressive symptoms in which the results were from Level II evidence (Grote et al., 2009: Level II; Leung & Lam, 2012: Level II).

The two main models of IPT can be described as follows:

3.3.1 IPT for women meets criteria of MDD: This intervention is recommended for women who meet the following qualifications:

1) Client Qualifications

1.1 Pregnant mothers who meet criteria for MDD diagnosis: Using Structural Clinical Interview Depression (SCID) to diagnose and have moderate to severe levels of depression severity as assessed by the Hamilton

Rating Scale of Depression (Ham-D)score ≥ 12) (Spinelli& Endicott, 2003: Level II; Brandon et al., 2012: Level IV).

1.2 Pregnant mothers aged 18 years old and above) (Spinelli& Endicott2003: Level II; Field et al., 2013: Level III; Brandon, et al., 2012: Level IV).

1.3 Gestational ages of 6- 36 weeks (Spinelli& Endicott, 2003: Level II; Field et al., 2013: Level III; Brandon et al., 2012: Level IV).Socio-economically deprived women (Spinelli& Endicott, 2003: Level II).

1.4 No mental disorders (Spinelli& Endicott, 2003: Level II; Field et al., 2013: Level III; Brandon et al., 2012: Level IV).

2) Therapist Qualifications

Therapists who will conduct group IPT require training and supervision (Spinelli& Endicott, 2003: Level II; Field et al., 2013: Level III).

3) Setting: Group Interpersonal Psychotherapy can be conducted at OPDs (Out Patient Department) of hospitals (Spinelli& Endicott, 2003: Level II; Field et al., 2013: Level III).

4) Type of therapy, duration and number of sessions

Individual IPT or group IPT can be used. For Individual IPT, the duration of therapy is four months with weekly sessions lasting for 45 minutes each (Spinelli& Endicott, 2003: Level II). For group IPT, The duration of the group intervention is three months. The sessions are conducted once a week with each session lasting one hour for a total of 12 weeks (Field et al., 2013: Level III). For assisted partner IPT, the duration of the sessions is 8 weeks (Brandon et al., 2012: Level IV).

5) Therapy Method

Individual IPT: During the assessment phase of MDD with pregnant mothers, the issues causing depression need to be determined and a good relationship must be built. From the application of IPT to the specific problems and needs of women with antenatal depression, the unique and developmental problems associated with gestation are added to the original interpersonal psychotherapy problem set: grief, interpersonal role disputes, role transitions and interpersonal deficits. The fifth broad area, complicated pregnancy, addresses problems specific to

gestation such as undesired pregnancy, medical problems associated with pregnancy itself, obstetrical complications, multiple births and congenital anomalies (Spinelli& Endicott, 2003: Level II). Manual on IPT developed by Klerman et al. (1984) issued to guide the interpersonal psychotherapy sessions (Spinelli& Endicott, 2003: Level II).

Group IPT: The main theme was pregnancy experience and relationship with problems. The curriculum was developed by a comprehensive guideline for interpersonal psychotherapy. In intrapersonal psychotherapy, the therapist is active during the intervention, using specific techniques for explanation, encouragement of affect, clarification, communication analysis and use of behavior modification techniques (Field et al., 2013: Level III). Comprehensive Guideline for Interpersonal Psychotherapy developed (Weismann et al., 1977).

The partner-assisted IPT (Brandon et al., 2012: Level IV), consisted of three phases over a span of eight sessions. The first phase of PA-IPT is characterized by accessing the depressive experience from the perspectives of both partners, eliciting how the partners each understand the events or stressors that may have occurred prior to the onset of depression and any associations they may have made between a “trigger” and the symptoms.

The middle phase of treatment aims to explore the role expectations each partner has of self and other, and the interactions between them that are perceived as supportive or, conversely, unsupportive.

The final phase consolidates changes, explores additional sources of support and processes what the experience of therapy has been like for each partner. To show their support system, every partner finishes the IPT “Circle of Closeness” identifying in three concentric circles those individuals in their social environments according to level of closeness. The circle of closeness is occasionally utilized as a point of reference, helping recognize which family or friends may be able to fill in remaining gaps of help or gaps likely to occur after points in the shift to a new role. Communication identifies the goal event or impotency linked and the therapist arranges role plays to illustrate new ways of questioning for help. In the last session, alternative ways are explained for both possible effect and approximate repetition.

6) Outcome Evaluation: Measurement of primary outcome includes the following:

1. The Hamilton Rating Scale of Depression is used (HRD) to evaluate the clinical symptoms of depression. If the Ham-D score is ≤ 6 , it means the women have recovered from MDD (Spinelli& Endicott, 2003: Level II; Brandon et al., 2012: Level IV).

2. The Edinburg Postnatal Depression Scale gives more attention to behavioral modification, not more attention to somatic changes. This measurement is preliminarily designed for postpartum mood states and is also use to measure sensitivity in pregnancy. The Edinburg Postnatal Depression Scale is the only one with a self-reported mood measuring scale validated for use in pregnancy and the postnatal period (sensitivity=86%, specificity=78%) (Spinelli& Endicott, 2003:Level II; Field et al., 2013:Level III; Brandon et al., 2012: Level IV).

7) Outcome Monitoring

The outcome of interpersonal psychotherapy is monitored after 6 week's completion of therapy (Brandon et al., 2012: Level IV).

3.3.2 IPT for women with mild to moderate depression: This intervention is recommended for women who have mild to moderate levels of depression and do not meet the following criteria for MDD diagnosis:

1) Client Qualifications

1.1 Pregnant mothers with scores of depressive symptoms at ≥ 12 measured by the Edinburg Postnatal Depression Scale (EPDS)(Grote. et al., 2009: Level II; Leung & Lam,2012: Level II).

1.2 Pregnant mothers aged 18 or above (Grote et al., 2009: Level II; Leung & Lam 2012: Level II).

1.3 Gestational ages of 10- 32 weeks (Grote et al., 2009: Level II; Leung & Lam, 2012: Level II).

1.4 No mental disorders (Grote et al., 2009: Level II; Leung& Lam, 2012: Level II).

2) Therapist Qualifications: Nurses who have backgrounds in psychology can conduct Interpersonal Psychotherapy after training and experience (Leung & Lam, 2012: Level II).

3) Setting: Hospital; outpatients of obstetrics and gynecology clinics where group IPT can be conducted (Grote et al., 2009: Level II; Leung & Lam, 2012: Level II).

4) Type of therapy, duration and number of sessions: Brief Group IPT is conducted over 4 weeks with 1.5 hours per IPT session (Grote et al., 2009: Level II; Leung & Lam, 2012: Level II). Group IPT is conducted over 4 weeks of intervention with 1.5 hours per session (Leung & Lam, 2012: Level II).

5) Therapy Method: The intervention involved the following three phases:

5.1. Engagement Phase: This is the motivational phase where the therapist builds good relationships with the pregnant mothers by building trust and find out which problems cause stress and depression.

5.2. Acute IPT-B Phase: In this phase, the therapist finds alternative solutions for the problem. For this purpose, video clips are used to encourage discussion with role-play for homework. Lastly, the therapist discusses how to control and manage emotion, which is more controllable.

5.3. Maintenance Phase: In the maintenance phase, the therapist helps the mothers effectively deal with social and interpersonal stressors associated with remission (Grote et al., 2009: Level II)

IPT-B was enhanced in a way that reflects seven components delineated in the culturally centered framework of Bernal and colleagues (Grote et al., 2009: Level II): persons, metaphors, concepts, content, goals, methods and contexts. For example, the researchers addressed the components of persons by employing therapists who were trained in cultural competence and had considerable experience working with persons of racial-ethnic minority groups who were living in poverty. The researchers also utilized the component of metaphors by displaying culturally relevant pictures of racially and ethnically diverse infants in the therapist's office and by using stories from the participants' cultural backgrounds to reinforce treatment goals. To address the component of concepts, therapists provided education about

depression in a way that was congruent with the participant's culture and used the word "stressed" instead of the word "depressed," if participant so desired, to minimize perceived stigma of depression. The component of content was addressed by exploring what coping mechanisms and cultural resources, such as spirituality or familismo, had helped participants through adversity in the past and by building on these resources during treatment. Therapists helped clients develop treatment goals that were personally and culturally relevant. Methods were addressed by intensive outreach and shortening treatment to reduce participant burden. Contexts were addressed by the pragmatic additions described above such as facilitation of access to needed social services.

Group antenatal intervention related to intergenerational conflict is described as follows (Leung & Lam, 2012: Level II): Strategies used to motivate participants' engagement in the intervention based on a group community-based family centered parenting program, COPE (Cunningham, 2006) including the following: (1) the use of a short video clip to stimulate discussion; (2) participant identification of errors and development of alternative strategies; (3) role-play; and (4) weekly homework for practice. Each of the four sessions had a distinct simple focus to ensure an understanding and clear take-home message. At the end of each session, the participants were given homework assignments to practice the skills or behaviors discussed in the session. The participants reported their practice at the beginning of the subsequent session and opportunity was provided for peer support and problem-solving.

Session 1 focused on motivating participants to achieve a better relationship with grandparents who were expected to be involved in childcare, and reviewed current problems and difficulties in the relationship associated with stress and depression.

Session 2 identified the consequences of poor and ineffective communications, set goals in managing the relationship and practiced skills of developing partnership in childcare.

Session 3 discussed interpersonal problem areas of role transitions and disputes in childcare, applied interpersonal techniques in role play, practiced specific communication and conflict management skills such as effective

listening, identification of common goals and expression of concerns assertively and in non-threatening ways.

Session 4 focused on emotional control and discussed the importance of managing personal emotions, which are more controllable than the external environment and others' responses in interactions.

6) Evaluation of Outcomes: The Edinburg Postnatal Depression Scale (EPDS) was used for measuring the primary outcome of Interpersonal Psychotherapy. A typical indication of treatment response was 50% reduction in symptom score on the EPDS (Grote et al., 2009: Level II; Leung & Lam, 2012: Level II).

7) Outcome Monitoring: The outcome was monthly assessment up to six months postpartum (Grote et al., 2009: level II).

CHAPTER IV

CONCLUSION AND SUGGESTION

4.1 Conclusion

The aim was of this study was to search, select, analyze and summarize current evidence-based practice on interpersonal therapy (IPT) for the management of depression with pregnant mothers. This topic was selected in line with the significance of a current problem worldwide. Depression is a major health problem and pregnant mothers with depression are increasing daily. In Bangladesh, 33% of pregnant mothers suffer antenatal depression (Gausia et al., 2009). Many factors contribute to antenatal depression for example, demographic, intrapersonal and interpersonal factors are responsible for antenatal depression. Antenatal depression not only affects mother's physical and mental health; it also affects fetal health and the conditions of the entire family.

According to the available evidence, depression during pregnancy can be reduced by using appropriate pharmacological and non-pharmacological interventions. Pharmacological treatment such as SSRI (selective serotonin reuptake inhibitors) and non-pharmacological treatment such as supportive or non directive therapy, cognitive behavior therapy, and interpersonal psychotherapy are all available. Non-pharmacological treatment is preferable to pharmacological treatment because the evidence has found pharmacological treatment during pregnancy to have side effects on the fetus such as increased risk for seizures, dehydration, excessive weight loss and hyperpyrexia (Kolko et al., 2005). Interpersonal psychotherapy is a non-pharmacological intervention for effective treatment and prevention of antenatal depression. As a psychiatric nurse, the author has an opportunity to play an important role in the care, administration and treatment of psychiatric patients. In the context of Bangladesh, a large number of pregnant mothers are suffering from depression. There are no guidelines on any management of depression with pregnant mothers.

Antenatal mothers with depression are treated together with other mental ill patients and nurses are instructed to follow physician's orders and give medication as prescribed. According to the scope of practice, psychiatric nurses can play a great role in applying interpersonal psychotherapy for mothers with antenatal depression. Interpersonal psychotherapy also offers extra benefits for pregnant mothers and nurses in building good interpersonal relationships.

For better management of mothers with antenatal depression, it would be best to increase knowledge about current scientific evidence-based practice, because this evidence supplies updated information with different types of pharmacological and non-pharmacological intervention for management of mothers with antenatal depression offers a description of the process of intervention and informs about the significance and advantages of intervention. All of the evidence illustrates the effectiveness of interpersonal psychotherapy for reducing antenatal depression.

As a pioneer in introducing interpersonal psychotherapy for antenatal depression in Bangladesh, the author has searched available current evidence using Mahidol University databases and websites in the search for related evidence. The Cumulative Index to Nursing and Allied Health (CINAHL), Ovid Full Text, ProQuest Nursing and Allied Health Source, PubMed, and Science Direct were also used to search for single research studies. The PICO framework was employed to guide the search terms. The keywords used in the search were "antenatal mother," "pregnant women," "prenatal mother," "interpersonal psychotherapy," "antenatal depression," and "depressive symptoms". The author used a Boolean operator in the search. For each of the PICO elements, the author collected any synonyms by connecting terms with "OR," then located citations that were relevant to all of the PICO elements by linking them with "AND," The evidence included systematic reviews of randomized controlled trials (RCTs), high quality single randomized controlled trials and quasi-experimental studies published in English from 2003 to 2014.

The author appraised the evidence by using the quality of the evidence-based practice including validity, reliability and applicability and evaluated strength of evidence-based practice as reported by Melnyk and Fineout-Overholt, (2011). The author's search yielded 57 articles related to the study. Finally, 5 articles were selected

for the study, all of which met the appraisal criteria. Of the aforementioned, three were RCTs, one was quasi-experimental and the other was a pretest-posttest design.

According to the analysis and synthesis of the evidence-based practice, the author recommends the following two IPT models: IPT for women meet the criteria of MDD and IPT for women with mild to moderate depression. From the research articles, the author was able to classify pregnant women into two groups, including pregnant women who meet criteria for Major Depressive Disorder (MDD) diagnosis and pregnant women with mild to moderate levels of depressive symptoms and do not meet the criteria of diagnosis for MDD. Therefore, IPT for women meet the criteria of MDD of comprised (16 weeks of group sessions) (Spinelli& Endicott, 2003: Level II) is suitable for pregnant women who meet the criteria for MDD diagnosis. Moreover, there are two types of IPT, group IPT (12 weeks of group sessions) (Field, Diego, Delgado, & Medina, 2013: Level III) and partner assisted IPT (8 weeks of sessions) (Brandon et al., 2012: Level IV) also effectively reduced antenatal depression in women who met the criteria for MDD diagnosis. However, the results came from lower levels of evidence; hence, the author will add some content as needed to the recommendations in this model. Another model, the IPT for women with mild to moderate depression, is also suitable for pregnant women who have mild to moderate levels of depressive symptoms and do not meet the criteria for MDD diagnosis. However, there is a type of group antenatal intervention which that adds issues related to managing intergenerational conflicts in childcare which can reduce depressive symptoms in which the results were from the strength of evidence rated at Level II (Grote et al., 2009: Level II; Leung & Lam, 2012: Level II).

4.2 Suggestion

It is recommended that women with antenatal depression should receive interpersonal psychotherapy to reduce their depressive symptoms with following application for practice following:

4.2.1 Implications for practice

1. The recommendations from this study should be utilized to develop a clinical practice guideline on using interpersonal psychotherapy for the management of depression with pregnant mothers.

2. The IPT for women with mild to moderate depression is suitable for implementation in Bangladeshi women. In this therapy, the characteristics of clients are pregnant mothers who have mild to moderate levels of depression which does not meet the criteria of MDD diagnosis. In this case, psychiatric professional nurses have an independent role in conducting the IPT for women with mild to moderate depression if they are trained. Moreover, mothers-in-law or grandmothers, or grandfathers can join in this program to solve intergenerational conflicts. Regarding the type of IPT, group IPT and the shorter duration and sessions of intervention would be better for enhanced access to care and decreased costs. Furthermore, the IPT for women with mild to moderate depression can prevent psychosocial stigma for mentally ill patients, because pregnant women can receive the intervention in the prenatal clinic or in the general hospital. After special training regarding IPT, nurses can apply this therapy approach to build good interpersonal relationships with the pregnant mothers and their relatives.

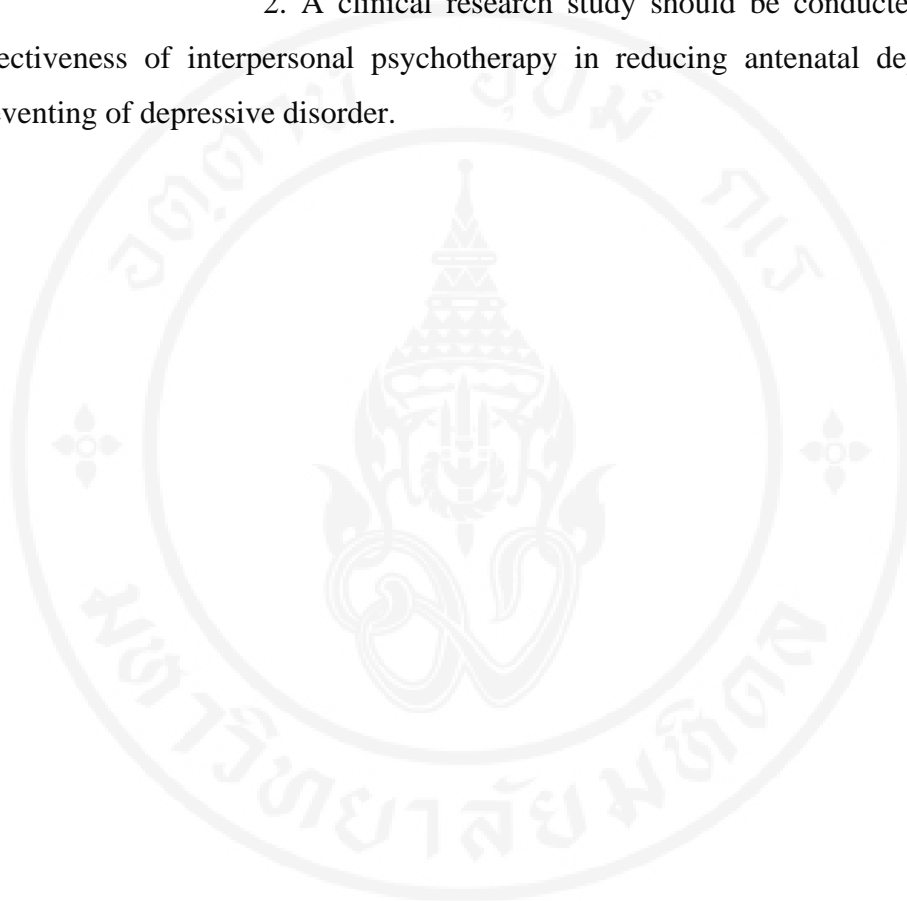
3. Nurses who are going to implement the clinical practice guideline for using IPT for women with mild to moderate depression need to be prepared by undergoing additional training on IPT for women with mild to moderate depression and receiving orientation from experts.

4. The pregnant mothers who receive prenatal services should be screened for antenatal depression by using the EPDS (Bangladeshi version) SCID for diagnosis of depressive disorder, if needed, in order to determine whether or not the pregnant mothers should receive IPT for women with mild to moderate depression, IPT for women meet the criteria of MDD or pharmacological treatment.

4.2.2 Implications for research

1. A pilot study should be conducted to evaluate acceptance, feasibility and cost-effectiveness of the IPT program provide which is by psychiatric nurses for antenatal depressive mother.

2. A clinical research study should be conducted to test the effectiveness of interpersonal psychotherapy in reducing antenatal depression and preventing of depressive disorder.



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