Effectiveness of interpersonal psychotherapy for reducing depressive symptoms in women diagnosed with postpartum depression in low- and middle-income countries: a systematic review

Harmeet Kaur Kang, Obrey Alexis, Bandana Bisht, Aaron Worsley, Manmeet Kaur, Denny John

Submitted to the Coordinating Group of:

☐	Crime and Justice
☐	Education
☐	Disability
☐	International Development
	☐ Nutrition
	☐ Food Security
☒	Social Welfare
☐	Methods
☐	Knowledge Translation and Implementation
☐	Business and Management
☐	Other:

Plans to co-register:

☐	No
☐	Yes ☐ Cochrane ☐ Other
☒	Maybe

Date submitted:
Date revision submitted:
Approval date:

Title of the review

Effectiveness of interpersonal psychotherapy for reducing depressive symptoms in women diagnosed with postpartum depression: a systematic review

Background

Postpartum depression (PPD), also known as post-natal depression, is a significant public health problem which affects approximately 12-19% of women after delivery globally (O'Hara & McCabe, 2013; Stewart et al., 2003). According to the DSM-V (Diagnostic Statistical Manual) diagnostic criteria (American Psychiatric Association, 2013), postpartum depression (PPD) is defined as a major depression episode during pregnancy or within 4 weeks of delivery. Whereas the International Classification of Diseases (ICD) guidelines state that the onset of postpartum depression is considered to be within 6 weeks after delivery (World Health Organization, 1992).

PPD is known to affect any woman regardless of the fact that she has an easy or problematic pregnancy. As per the American Psychiatric Association (APA), there is no impact on PPD due to factors such as age, ethnicity, education and income (APA, 2016). Postpartum depression can predispose to chronic or recurrent depression, which may affect the mother–infant relationship and child's growth and development. Further, children of mothers with postpartum depression have greater cognitive, behavioural and interpersonal problems as compared with the children of non-depressed mothers (O'Hara & Swain, 1996). Several social factors such as unmarried mothers and unplanned pregnancy, perceived lack of support from partner, parents, relatives and friends during postpartum period and impaired interpersonal relationships between women with postpartum depression and their spouse (M.W. O'Hara, 1994), have been shown to contribute towards PPD among women (Cox, Connor, Handerson, McGuire, and Kendall, 1983; O'Hara, 1994).

Many studies have demonstrated the efficacy of interpersonal psychotherapy (IPT) in depression over other psychological treatments (Beeber et al., 2013; Bolton et al., 2003; Mufson et al., 2004; Posmontier, Neugebauer, Stuart, Chittams, & Shaughnessy, 2016). Various organisations such as the American Psychiatric association, American Psychological Association and National Institute for Health and Clinical Excellence in UK, have recognised IPT as an efficacious psychological therapy (Markowitz JC, 2012) .

IPT has been suggested as most relevant to postpartum depression as IPT targets these specific interpersonal problems experienced by women in postpartum period by several studies (Stuart, 2012; O'Hara, 1994, O'Hara et al., 1996). Recently, the World Health Organisation (WHO) has also recommended IPT as the first choice of treatment for post-partum depression as also several other studies (Beeber et al., 2013; Bolton et al., 2003; Mufson et al., 2004; Posmontier et al., 2016; World Health Organization, 2016). Despite the growing number of empirical studies on postpartum depression, there is a lack of robust

systematic evidence on efficacy of IPT to treat PPD. Therefore, this systematic review will determine the usefulness of IPT to treat PPD.

Policy relevance

It has been reported by the World Health Organization (WHO) that the availability of specialized and general health workers dealing with mental health in low and middle income countries (LMICs) is grossly insufficient, which is the one of important factors for the lack of access to mental health services for persons with mental disabilities (WHO, 2015). Keeping in mind these issues, the WHO Mental Health Gap Action Program (mhGAP) has recommended the scaling up of services for mental, neurological and substance use disorders, especially in LMICs (WHO, 2016). Among the psychological therapies, WHO has recommended and also published a manual on group IPT for depression that can be administered by non-specialist providers in mental health but have some training in IPT (WHO & Columbia University,2016).

The WHO (2015) recommended that evidence based psychological interventions such as IPT and CBT should be the first line treatment for pregnant and breast-feeding women with moderate-severe depression. While CBT can only be delivered by specialized and trained psychologist, individual IPT can be delivered by mental health professionals such as physicians, psychologists, nurses and social health workers. Further group IPT can be delivered by supervised facilitators who may not have received previous training in mental health (WHO & Columbia University, 2016). Therefore, in line with the vision and goals of WHO's Comprehensive Mental Health Action Plan 2013-2020 (WHO, 2013), IPT can be suggested as the most accessible and affordable therapy among all psychotherapies which can be delivered in general health care and community-based settings by non-specialized individuals as well (WHO and Columbia University, 2016).

The present review will be useful in generating the evidence on the efficacy of IPT in the treatment of PPD. The generated evidence from the review would have long term policy implications in the provision of accessible and affordable mental health care to women during pregnancy and breast-feeding period, especially in LMICs.

Objectives

Primary objective:

What is the effectiveness of IPT for reducing depressive symptoms in women diagnosed with postpartum depression in LMICs?

Secondary objectives:

1. What is the effectiveness of interpersonal psychotherapy alone or in combination with pharmacological therapy in reducing depressive symptoms in women diagnosed with postpartum depression in LMICs?

2. What is the effectiveness of interpersonal psychotherapy in comparison with pharmacological therapy and other psychological and psychosocial interventions?
3. What is the effectiveness of interpersonal psychotherapy according to mode i.e. individual, group, conjoint and telephonic; on reducing depressive symptom in postpartum depression?
4. What is the effectiveness of standard IPT (16 sessions) versus brief IPT (8- 12 sessions) on reducing depressive symptoms in postpartum depression?

Existing reviews

Boath, E., Bradley, E., & Henshaw, C. (2005). The prevention of postnatal depression: a narrative systematic review. *Journal of Psychosomatic Obstetrics & Gynecology*, *26*(3), 185-192. Boath and Colleagues reviewed 21 randomized controlled trails to evaluate the effectiveness of preventive interventions on postnatal depression. According to the results of this narrative review, short-term efficacy of IPT was documented in nine trials which included seven psychological and supportive interventions, one antidepressant trial and one calcium carbonate trial. None of the trails documented long term efficacy. In their review, they included two trials on the impact of IPT on PPD prevention, both the studies found efficacy of IPT in prevention of depression symptoms, but both the studies had small sample size & limited power, so they suggested further research in this area (Boath, Bradley, & Henshaw, 2004).

Dennis, C. L. (2005). Psychosocial and psychological interventions for prevention of postnatal depression: systematic review. *Bmj*, *331*(7507), 15. In this systematic review, researchers compared psychological & psychosocial interventions with the usual antepartum; intra-partum and postpartum care for prevention of postpartum depression. Fifteen (15) RCTs with a total sample of 7697 women were included. There was no significant effect of all types of interventions on prevention of postnatal depression (RR 0.81, 95% confidence interval 0.65-1.02). Further they found that intensive postpartum support provided by health professionals had a significant effect on prevention of postnatal depression. (0.68, 0.55-0.84). Individual interventions were more effective than group interventions. In addition they found no significant effect of interpersonal psychotherapy (IPT) on prevention of PPD. (two trials, n=72, 0.31, 0.04-2.52). This review included only two RCTs on the effects of IPT on prevention of PPD, with small sample size. Further, this review is conducted on the preventive aspect of IPT rather than treatment of PPD (Dennis, 2005).

Dennis C.L., Hodnett E.D. (2007). Psychosocial & psychological interventions for treating postpartum depression. Cochrane Database of Systematic Reviews. 4. Art. no. CD006116. DOI: 10.1002/14651858 CD0006116.pub2. This systematic review aimed to assess the effectiveness of all psychosocial & psychological interventions compared with usual postpartum care in the reduction of depression symptomatology. Ten trials were eligible for the inclusion in the review, out of which nine trials reported outcomes for 956 women. They found that all psychosocial and psychological interventions were effective in reducing the depressive symptomatology at final assessment within first year postpartum (nine trials,

n=956, RR 0.70, 95% confidence interval 0.60-0.81). Further, they reported that individual based interventions had beneficial effect in the treatment of postpartum depression symptomatology (eight trials, n=917, RR 0.71, 95% CI 0.61- 0.82). But only one trail that examined the effectiveness of IPT in decreasing depressive symptomatology was included. Further they reported that methodology of the included studies was weak and there is need for larger trails to provide clear conclusion about specific intervention benefits (Dennis & Hodnett, 2007).

Sockol, L.E., Epperson, C.N., Barber J.P. (2011). A meta-analysis of treatment for perinatal depression. Clinical Psychology Review, 31(5), 839-849. This review conducted meta-analysis of 27 studies including open trials (n=9), quasi-randomized trials (n=2) and RCTs (n=16) to review the efficacy of pharmacologic and psychological interventions for treatment of perinatal depression. IPT was found to be superior than CBT in treating perinatal depression. Individual psychotherapy had better efficacy than group psychotherapy. However, the purported effect of psychological intervention could be because the researchers did not excluded the 8 trials where participants were receiving both psychological as well as pharmacological treatments. Further research was recommended where psychological and pharmacological interventions are reviewed alone as well as in combination.

Miniati, M., Callari, A., Calugi, S., Rucci, P., Savino, M., Mauri, M., & Dell'Osso, L. (2014). Interpersonal psychotherapy for postpartum depression: A systematic review. Archives of Women's Mental Health, 17(4), 257–268. There is only one systematic review available on the effectiveness of IPT on PPD which is limited to the data existing between 1995 and 2013. They included 11 research studies, which evaluated the efficacy of individual and group IPT for PPD. They concluded that Individual and group IPT are efficacious interventions for mothers with postpartum depression. IPT was not immediately associated with rapid remission but it leads to mid-term or long-term efficacy for PPD (Miniati et al., 2014).

Tsivos, Z.-L., Calam, R., Sanders, M. R., & Wittkowski, A. (2015). Interventions for postnatal depression assessing the mother–infant relationship and child developmental outcomes: a systematic review. *International Journal of Women's Health*, *7*, 429–447. http://doi.org/10.2147/IJWH.S75311. This review selected 19 studies which included a treatment or intervention delivered in postnatal period with outcome as maternal depression, mother-infant relationship and/or child outcomes. They reported that interventions that focused on dyadic relationship such as mother-infant therapy and coaching interventions for mother responsiveness were most effective in reducing postnatal depression but the effect sizes of these studies were modest. Interventions for quality of dyadic relationships were effective in improving the quality of mother-infant relationship, but only four studies measured child development outcomes and resulting effect sizes were also small. They did not report intergenerational transmission of risk to children i.e. whether mother-infant relationships improved due to improvement in developmental outcomes or improvement in postnatal depression. The interventions included in the studies were IPT, CBT, mother infant therapy, dyadic psychotherapy and coaching interventions etc.

Morrell, C.J., Sutcliffe, P., Booth, A., Stevens, J., Scope, A., Stevenson, M., Harvey, R., Bessey, A., Cantrell, A., Dennis, C.L., Ren, S., Ragonesi, M., Barkham, M., Churchill, D., Henshaw, C., Newstead, J., Slade, P., Spiby, H., Stewart-Brown, S. (2016). A systematic review, evidence synthesis and meta-analysis of quantitative and qualitative studies evaluating the clinical effectiveness, the cost-effectiveness, safety and acceptability of interventions to prevent postnatal depression. *Health Technology Assessments*. May, 20(37), 1-414. This review analyzed the clinical effectiveness, cost-effectiveness, safety and acceptability of various interventions to prevent post-partum depression. A total of 122 quantitative and 56 qualitative studies were reviewed. The results showed midwifery redesigned postnatal care, person-centred approach (PCA)-based and cognitive-behavioural therapy (CBT)-based intervention, interpersonal psychotherapy (IPT)-based intervention and education on preparing for parenting , promoting parent-infant interaction and peer support as the most beneficial interventions to prevent PPD. Midwifery redesigned postnatal care, PCA-based intervention and IPT-based intervention came out be the most cost-effective treatments available for PPD. The study supports IPT as a beneficial and cost-effective treatment for PPD. However, some gaps for further research are identified in this study. It does not compare Group –IPT, IPT-B (Brief IPT), individual IPT or telephone- led IPT in terms of effectiveness. Comparison of psychological interventions with pharmacotherapy was also conducted. The researchers have included only those studies where Edinburgh Postnatal Depression Scale (EPDS) was used to diagnose PPD.

O'Connor, E., Rosson R.C., Henninger, M., Groom, H.C., Burda, B.U. (2016). Primary case screening for and treatment of depression on pregnant and postpartum women: evidence report and systematic review for the US Prevention Service Task Force. *JAMA*, 315(4), 388-406. This review mainly focussed on effectiveness of depression screening programs and treatment in pregnant and postpartum women on health outcomes. They included 6 trials (n=11869), to assess the effectiveness of screening programs and reported that screening programs reduce overall prevalence of depression and increase the likelihood of remission. Further they reported effectiveness of CBT for pregnant and postpartum women screened for depression in increasing the likelihood of remission (10 studies) (Pooled RR 1.34 [95% CI, 1.19-1.50]) as compared to usual care. Observational studies (12 studies, n= 4759735) evidence suggested association of second-generation anti-depressants with potentially serious harms to mother as well as infant. They did not report regarding interpersonal therapy's effectiveness in remission of depression.

Few of the previous reviews and meta-analysis have evaluated the effectiveness of all psychosocial and psychological treatments on post-partum depression (Dennis & Hodnett, 2007; Sockol et al., 2011; O'Connor et al., 2016). These reviews had very few trials for the effectiveness of IPT on PPD, as result of which any conclusion regarding effectiveness of IPT on PPD were not reported. The existing reviews have focussed on depression symptoms reduction only (Dennis & Hodnett, 2007, Sockol et al., 2011); they did not study the moderators for efficacy of intervention such as mode of IPT, duration of IPT (number of sessions) and combination of IPT and pharmacotherapy etc. Only one systematic review was found to be conducted specifically on effectiveness of IPT on PPD, but only one outcome, i.e. depression symptoms remission, was studied (Miniati et al., 2014). Other related outcomes

such as maternal-infant relationship, social adjustment, social support, couple and infant outcomes and harmful effects of IPT etc. were not assessed. One review studied effects of dyadic relationship focussed interventions on the mother-infant relationships and child outcomes, but did not provide any substantial evidence as to whether improvement in mother -infant relationship was due to reduced postpartum depression or developmental outcomes (Tsivos et al., 2015). Other reviews have focused on prevention of postpartum depression rather that treatment (Dennis, 2005; Boath et al., 2005; Morrell et al. 2016).

The present review will focus on effectiveness of IPT alone or in combination with pharmacotherapy on depressive symptoms reduction, recovery and remission of depressive symptoms. Secondary outcome will include maternal, infant, couple and adverse effects outcomes. Further this review will evaluate the effectiveness of IPT in comparison with pharmacotherapy, psychological and psychosocial therapies and in regard to mode and duration of intervention as well.

Intervention

Interpersonal psychotherapy is a brief time limited psychotherapy in which the focus of the treatment is current concerns and improving interpersonal relationships. IPT has demonstrated efficacy in the treatment of affective disorders, anxiety disorders, eating disorders, Post traumatic stress disorder and depression (Omay & Stuart, 2013). IPT has wide adaptability; it can be provided in all settings, hospital as well as community settings and can be given individually as well as in group (World Health Organization, 2016). IPT is based on the principle that relationships and life events impact mood and that the reverse is also true. It was developed by Gerald Klerman and Myrna Weissman for major depression in the 1970s and has since been adapted for other mental disorders. Four problem areas explored in IPT (Klerman & Weissman, 1993; Omay & Stuart, 2013; World Health Organization, 2016) are grief, role disputes, life changes/role transition and loneliness/social isolation/Interpersonal deficits. Phases of IPT include initial, middle and termination phase.

Interventions for the review will include IPT alone or IPT in combination with pharmacological treatment given to women with post-partum depression. For the purposes of this review, IPT will be defined as an acute treatment that would generally be conducted across three phases: (1) assessment through psychiatric/social history (including current social functioning and close relationship, their patterns, and mutual expectations), and linkages between the current interpersonal situation within one of the four interpersonal problem areas (i.e. grief, interpersonal role disputes, role transitions or life changes, or loneliness/social isolation/interpersonal deficits) to set the framework for treatment; (2) pursuit of strategies that are specific to the chosen interpersonal problem area; and (3) encouragement to recognize and consolidate therapeutic gains and develop ways to identify and counter depressive symptoms should it arise in the future (Dennis & Hodnett, 2009). Where relevant, Group IPT would include a short intervention (8 sessions) with 6-10 members per group with each session lasting 90 minutes or if there are more than 10 people

the session could go up to 2 hours so as to allow sufficient time for different group members to speak (WHO, 2016).

Treatment comparisons

1. IPT and usual or standard care (i.e. business as usual)
2. IPT and pharmacotherapy
3. IPT alone and IPT with pharmacotherapy
4. IPT and combination of psychological and psychosocial interventions
5. IPT and pharmacotherapy compared with psychological and psychosocial interventions with pharmacotherapy

Population

Women with symptoms of depression developed during pregnancy or within 6 weeks post-delivery, identified either through clinical diagnosis (DSM-IV, ICD-10) or self-reported measures e.g. Beck Depression Inventory (BDI), EPDS (Edinburg Postnatal Depression Scale), Public Health Questionnaire (PHQ-9) , Hamilton Rating Scale for Depression (HRSD), Postpartum Depression Scale (PPDS), Major Depression Inventory (MDI), Inventory to Diagnose Depression (IDD), Center for Epidemiological Studies Depression Scale (CES-D) and Zung Self rating depression scale (SDS).

Outcomes

Primary outcome: Depressive symptoms such as severity, symptom remission, recovery status, and relapse.

Secondary outcomes:

Maternal outcomes: Mother-infant bonding/attachment, anxiety, social support, postpartum adjustment, social adjustment, transition back to work
Couple outcomes: Marital adjustment, sexual interest
Adverse effects outcomes: Suicide attempts, suicides, number of hospitalizations, duration of hospitalizations, lost workdays

Study designs

Two-arm randomized controlled trials will be included including multi-arm trials (where IPT is compared with combination), factorial designs (where IPT and pharmacotherapy is compared to psychosocial interventions with pharmacotherapy), and quasi-experimental designs (controlled before and after, uncontrolled before and after).

Other study designs such as case reports, case series, reviews and non-original studies such as editorials, book reviews, commentaries, and letters to editors, will be excluded.

References

American Psychiatric Association. (2013). *Cautionary Statement for Forensic Use of DSM-5. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*. https://doi.org/10.1176/appi.books.9780890425596.744053

APA. (2016). What is Postpartum Depression.

Beeber, L. S., Schwartz, T. A., Holditch-Davis, D., Canuso, R., Lewis, V., & Hall, H. W. (2013). Parenting enhancement, interpersonal psychotherapy to reduce depression in low-income mothers of infants and toddlers: a randomized trial. *Nursing Research*, *62*(2), 82–90. https://doi.org/10.1097/NNR.0b013e31828324c2

Boath, E., Bradley, E., & Henshaw, C. (2004). Women's views of antidepressants in the treatment of postnatal depression. *Journal of Psychosomatic Obstetrics and Gynecology*, *25*(3–4), 221–233. https://doi.org/10.1080/01674820400017889

Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., … Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda. *JAMA : The Journal of the American Medical Association*, *289*(23), 3117–3124. https://doi.org/10.1001/jama.289.23.3117

Cuijpers, P. (2016). Are all psychotherapies equally effective in the treatment of adult depression? The lack of statistical power of comparative outcome studies. *Evidence Based Mental Health*, *19*(2), 39–42. https://doi.org/10.1136/eb-2016-102341

Dennis C, L., & Hodnett, E.D. (2007). Psychosocial and psychological interventions for treating postpartum depression. Cochrane Database of Systematic Reviews, Issue 4, Art No.: CD006116. DOI: 10.1002/14651858.CD006116.pub2

Dennis, C.-L. (2005). Psychosocial and psychological interventions for prevention of postnatal depression: systematic review. *BMJ (Clinical Research Ed.)*, *331*(7507), 15. https://doi.org/10.1136/bmj.331.7507.15

Hunsley, J., Elliott, K., & Therrien, Z. (2013). The efficacy and effectiveness of psychological treatments, 1–29. https://doi.org/10.1037/a0036933

Kathryn L Bleiberg, J. C. M. (2005). A pilot study of interpersonal psychotherapy for posttraumatic stress disorder. *The American Journal of Psychiatry*, *162*(1), 181–183. Retrieved from http://ajp.psychiatryonline.org/

Klerman, G. L., & Weissman, M. M. (1993). Interpersonal psychotherapy for depression: Background and concepts. *New Applications of Interpersonal Psychotherapy*. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi

Markowitz JC, W. M. (2012). Interpersonal psychotherapy: Past, present and future. *Clinical Psychology & Psychotherapy*, *19*(2), 99–105. https://doi.org/10.1002/cpp.1774

Miniati, M., Callari, A., Calugi, S., Rucci, P., Savino, M., Mauri, M., & Dell'Osso, L. (2014). Interpersonal psychotherapy for postpartum depression: A systematic review. *Archives of Women's Mental Health*, *17*(4), 257–268. https://doi.org/10.1007/s00737-014-0442-7

Mufson, L., Dorta, K. P., Wickramaratne, P., Nomura, Y., Olfson, M., & Weissman, M. M. (2004). A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. *Archives of General Psychiatry*, *61*(6), 577–584. https://doi.org/10.1001/archpsyc.61.6.577

O'Connor, E., Rosson R.C., Henninger, M., Groom, H.C., Burda, B.U. (2016). Primary case screening for and treatment of depression on pregnant and postpartum women: evidence report and systematic review for the US Prevention Service Task Force. *JAMA*, 315(4), 388-406.

O'Hara, M. W., Stuart, S., Gorman, L. L., & Wenzel, A. (2000). Efficacy of interpersonal psychotherapy for postpartum depression. *Archives of General Psychiatry*, *57*(11), 1039–1045. https://doi.org/10.1001/archpsyc.57.11.1039

O'hara, M. W., & Swain, A. M. (1996). Rates and risk of postpartum depression—a meta-analysis. *International Review of Psychiatry*, *8*(1), 37–54. https://doi.org/10.3109/09540269609037816

Omay, O., & Stuart, S. (2013). Interpersonal psychotherapy (IPT): A short introduction. *Bulletin of Clinical Psychopharmacology*, *23*, S2.

Posmontier, B., Neugebauer, R., Stuart, S., Chittams, J., & Shaughnessy, R. (2016). Telephone-administered Interpersonal psychotherapy by Nurse-Midwives for postpartum depression. *Journal of Midwifery and Women's Health*, *61*(4), 456–466. https://doi.org/10.1111/jmwh.12411

Power, M. J., & Freeman, C. (2012). A Randomized Controlled Trial of IPT Versus CBT in Primary Care: With Some Cautionary Notes About Handling Missing Values in Clinical Trials. *Clinical Psychology & Psychotherapy*, *19*(2), 159–169. https://doi.org/10.1002/cpp.1781

Tsivos, Z.-L., Calam, R., Sanders, M. R., & Wittkowski, A. (2015). Interventions for postnatal depression assessing the mother–infant relationship and child developmental outcomes: a systematic review. *International Journal of Women's Health*, *7*, 429–447.

World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders. *International Classification*, *10*, 1–267. https://doi.org/10.1002/1520-6505(2000)9:5<201::AID-EVAN2>3.3.CO;2-P

World Health Organization. (2012). *Q 3: Is brief, structured psychological treatment in non-specialist health care settings better (more effective than/as safe as) than treatment as usual in people with depressive episode/disorder?* Retrieved fromhttp://www.who.int/mental_health/mhgap/evidence/resource/depression_q3.pdf

World Health Organization. (2016). Group interpersonal therapy (IPT) for depression. World Health Organization (WHO). mhGAP Evidence Resource Centre. WHO, Geneva, 2015.

World Health Organization (WHO). mhGAP intervention guide for mental, neurological and substance use disorders in no-specialized health settings: Mental Health Gap Action Programmme (mhGAP) (Version 2.0). WHO, Geneva, 2016.

World Health Organization and Columbia University. Group Interpersonal therapy (IPT) for depression (*WHO, generic field-trial version 1.0).* WHO, Geneva, 2016

World Health organization (WHO). Comprehensive Mental Health Action Plan 2013-2020, 66th World Health Assembly WHA66.8, dated 27 May 2013. Retrieved from http://www.who.int/mental_health/action_plan_2013/en/

Review authors

Lead review author: The lead author is the person who develops and co-ordinates the review team, discusses and assigns roles for individual members of the review team, liaises with the editorial base and takes responsibility for the on-going updates of the review.

Name:	Harmeet Kaur Kang
Title: Principal	Principal
Affiliation:	Chitkara University, Punjab, India
Address:	Chitkara School of Health Sciences, Chitkara University, Rajpura, Punjab, India- 140401
City, State, Province or County:	Rajpura, Punjab, India
Post code:	140401
Country:	India
Phone:	+91-9815143237
Email:	harmeet.kaur@chitkara.edu.in

Co-author (1)

Name:	Obrey Alexis
Title:	Senior Lecturer
Affiliation:	Oxford Brookes University, UK
Address:	Oxford Brookes University, Joel Joffe Building, 900 Delta Office Park, Welton Road
City, State, Province or County:	Swindon, UK
Post code:	SN5 7XQ
Country:	UK
Phone:	+44 (0) 1865485204
Email:	oalexis@brookes.ac.uk

Co-author (2)

Name:	Bandana Bisht
Title:	Vice Principal
Affiliation:	Chitkara University, Punjab, India
Address:	Chitkara School of Health Sciences, Chitkara University, Rajpura, Punjab, India- 140401

City, State, Province or County:	Rajpura, Punjab, India
Post code:	140401
Country:	India
Phone:	+91-9888433442
Email:	bandana.bisht@chitkara.edu.in

Co-author (3)

Name:	Aaron Worsley
Title:	Academic Liaison Assistant
Affiliation:	Oxford Brooks University, UK
Address:	Oxford Brookes University, Joel Joffe Building, 900 Delta Office Park, Welton Road
City, State, Province or County:	Swindon, UK
Post code:	SN5 7XQ
Country:	UK
Phone:	+44(0)1865483135
Email:	aworsley@brookes.ac.uk

Co-author (4)

Name:	Manmeet Kaur
Title:	Assistant Professor
Affiliation:	Chitkara University, India
Address:	Chitkara School of Health Sciences, Chitkara University, Rajpura, Punjab, India- 140401
City, State, Province or County:	Rajpura, Punjab, India
Post code:	140401
Country:	India
Phone:	01762- 507085 Ext-547
Email:	manmeet.tathgur@chitkara.edu.in

Co-author (5)

Name: Denny John	Denny John
Title:	Evidence Synthesis Specialist

Affiliation:	Campbell Collaboration
Address:	2nd Floor, West Wing, ISID Complex, Vasant Kunj
City, State, Province or County:	New Delhi, Delhi
Post code:	110070
Country:	India
Phone:	+91-9987021553
Email:	djohn@campbellcollaboration.org

Roles and responsibilities

- Content: Bandana Bisht
- Systematic review methods: Harmeet Kaur, Obrey Alexis, Denny John, Bandana Bisht, Manmeet Kaur
- Statistical analysis: Denny John, Harmeet Kaur
- Information retrieval: Denny John, Aaron Worsley

Funding

Do you receive any financial support, and if so, from where? What are your deliverable deadlines for the review? If not, are you planning to apply for funding, and if so, from where?
No.

Potential conflicts of interest

Please read the Campbell conflict of interest policy (October 2013). Ask each of your co-authors to fill in a conflict of interest form (available in the policy), then describe any potential conflicts here. For example, have any of the authors been involved in the development of relevant interventions, primary research, or prior published reviews on the topic? Please submit your forms with the title registration form.
No Potential conflicts involved.
Bandana Bisht is a trained IPT therapist. At present, she is not conducting any primary research in IPT for postpartum depression.

Preliminary timeframe

Note, if the protocol or review is not submitted within six months and 18 months of title registration, respectively, the review area is opened up for other authors.

- Date you plan to submit a draft protocol: September 2018
- Date you plan to submit a draft review: September 2019