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Best Practices

Prenatal Depression: Best Practice Guidelines for Diagnosis and Treatment

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The purpose of this article is to provide counselors with an overview of best practices for the treatment of women who experience prenatal depression (PND). The authors first discuss issues in the screening and diagnosis of PND. Next, the 2 most common treatments, antidepressants and psychotherapy, are reviewed and discussed in relation to current best practice guidelines. Guidelines for counselors' roles in treatment and advocacy are also provided.

Depression is a chronic and recurrent condition that is one of the leading causes of disability for women globally (Murray & Lopez, 1997). Women are two to three times more likely to have depression compared with men, with peak prevalence rates occurring during a woman's child-bearing years (American Psychiatric Association [APA], 2000; Halbreich, 2004; Kornstein, 1997). It was once thought that pregnancy provided protection from depression, but epidemiological data have shown comparable rates for pregnant and nonpregnant women (Gavin et al., 2005; Vesga-López et al., 2008). The prevalence rates for major depressive disorder (MDD) in pregnant women range from 7% to 13% (Bennett, Einarson, Taddio, Koren, & Einarson, 2004; Bland, 1997; J. Evans, Heron, Francomb, Oke, & Golding, 2001). However, these rates are almost tripled for certain high-risk groups, including women who are low income, minority status, adolescent, single and living alone, or have a previous history of MDD (Bennett et al., 2004; Da Costa, Larouche, Dritsa, & Brender, 2000; Hobfoll, Ritter, Lavin, Hulsizer, & Cameron, 1995; Pearlstein, 2008; Zayas, Cunningham, McKee, & Jankowski, 2002).

Untreated depression during pregnancy has a number of adverse outcomes not only for the mother but also for her unborn child. Prenatal depression (PND) is associated with poor nutrition and inadequate prenatal medical care as well as alcohol and tobacco use (Halbreich, 2004; Pearlstein, 2008; Van den Bergh, Mulder, Mennes, & Glover, 2005). PND is also related to increased rates of preterm delivery, autonomic anomolies in the fetus, lower birth weight, and complications during delivery (Halbreich, 2004; Pearlstein, 2008). There is also evidence that PND predicts a number of postpartum problems, including maternal depression and cognitive and behavioral complications in the child (Van den Bergh et al., 2005).

Despite the prevalence of PND and its potential adverse outcomes, effective treatment is complicated by three major factors. First, depression is underdetected in pregnant women because its symptoms can mimic common symptoms of pregnancy (e.g., poor sleep, fatigue) and related health conditions (e.g., anemia, gestational diabetes; Moses-Kolko & Roth, 2004; Yonkers, Smith, Gotman, & Belanger, 2009). Second, pregnant women who consider whether or not to continue or start an antidepressant are faced with the vexing decision of weighing the benefits of treating the depression against the risks of possible birth defects and pregnancy complications associated with taking antidepressants (Cohen et al., 2006; Freeman, 2007). Third, although empirically supported psychotherapies have been identified for pregnant women who are depressed (Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Spinelli & Endicott, 2003), information regarding these treatments is not well disseminated in counseling literature or in training programs, and counselors might not be familiar with these approaches. For example, a search of counseling journals published by the American Counseling Association (ACA) during the past 10 years yielded no articles regarding pregnancy-related counseling issues, including prenatal depression.

Because of this gap in the literature, it is clear that counselors need the training and skills necessary for providing effective counseling for pregnant women. In addition, they need knowledge to skillfully advocate with and on behalf of clients as they make decisions about treatment options (Ratts & Hutchins, 2009). To this end, the purpose of this article is to provide counselors with an overview of best practices for treating women with prenatal depression. First, we discuss issues in screening and diagnosis. Next, we review and discuss the two most common treatments for PND—antidepressants and psychotherapy—in relation to the following published practice guidelines: the Agency for Healthcare Research and Quality's (Gaynes et al., 2005) guidelines on screening and assessment, the APA's (2010) newly revised practice parameters

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for assessing and treating major depression, and the American College of Obstetricians and Gynecologists' (ACOG; 2008) guidelines for the perinatal use of psychiatric medications. In our discussion of psychotherapy, interpersonal therapy (IPT) is described in particular detail, because it is currently the best studied treatment and is highly relevant for counselors in their clinical practice with women experiencing PND. Finally, we provide guidelines for counselors in providing treatment for women during pregnancy and for advocating on their behalf as they face important treatment decisions.

Issues in Screening and Diagnosis

Most of the research literature in the area of PND has investigated either MDD or minor depression (Gaynes et al., 2005). According to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM–IV–TR*; APA, 2000), MDD consists of one or more major depressive episodes (MDEs). An MDE is defined as a syndrome of at least five of nine depressive symptoms that persist for 2 weeks or more. These symptoms are depressed mood, loss of interest or pleasure in usual activities, appetite disturbance (decrease or increase), sleep disturbance (insomnia or hypersomnia), psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, concentration problems or indecisiveness, and suicidal ideation or gestures. Minor depression is characterized by at least two to four depressive symptoms that last for at least 2 weeks (APA, 2000). The major risk factor for depression in pregnant women is a previous history of an MDE (Cohen et al., 2006). Higher rates of depression are also associated with lower socioeconomic status, minority status, increased stressful life events, and low levels of social support (Bennett et al., 2004; Gavin et al., 2005; Halbreich, 2004). The literature generally indicates that there are no significant differences in depression across trimesters (Bennett et al., 2004; Gavin et al., 2005).

Accurate diagnosis and screening are challenging because it may be difficult to distinguish depression from pregnancy-related conditions. Depression can be underdiagnosed because women and health professionals attribute depressive symptoms to aspects of pregnancy (Yonkers et al., 2009) or pregnancy-related medical conditions (e.g., anemia, gestational diabetes, or hypothyrioidism; Moses-Kolko & Roth, 2004). Conversely, overdiagnosis of depression can occur when mental health professionals misinterpret common somatic symptoms of pregnancy (e.g., poor sleep, fatigue, emotional lability, food cravings, nausea, concentration problems, and feeling overweight) as markers of depression (Moses-Kolko & Roth, 2004). Contributing to this problem, common depression screening instruments may yield false positives due to the inclusion of a number of somatic symptoms (Salamero, Marcos, Gutiérrez, & Rebull, 1994; Yonkers et al., 2009). For example, the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979; Beck, Steer, & Brown, 1996) is probably the most widely used depression screening instrument. However, it is less indicated for PND because of its reliance on various physical symptoms of depression (e.g., appetite disturbance, sleep problems, fatigue; Gaynes et al., 2005).

In contrast, the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) is a 10-item questionnaire that was developed to screen for prenatal and postpartum depression without the confounding influence of somatic items (Gordon, Cardone, Kim, Gordon, & Silver, 2006; Yonkers et al., 2009). The EPDS has been the most systematically tested prenatal screening instrument (Gaynes et al., 2005) and has English and Spanish versions that have been validated. A positive screen (score of 13 or higher) is indicative of possible major depression (Gaynes et al., 2005).

For counselors who wish to use less formal screening, the following are some effective questions: "Over the past two weeks have you felt little interest or pleasure doing things?" or "Over the past two weeks have you felt down, depressed, or helpless?" (Stewart, 2006, p. 1). To distinguish between depression and symptoms of pregnancy, Spinelli and Endicott (2003) recommended that counselors ask what happens when there is a temporary abatement of symptoms. For example, a counselor might ask: "If you did experience an increase in energy or were able to get better sleep, would you be interested in continuing your usual activities? If your nausea were to abate, would you be interested in eating?" Any positive screen should be followed up with an in-depth diagnostic evaluation (APA, 2010; Gaynes et al., 2005). This assessment should include collaboration with the client's regular health care provider to ensure integration of care and to rule out physical conditions that could be contributing to current symptomatology (ACOG, 2008; APA, 2010; Gaynes et al., 2005).

Treatments for PND

Treatments for prenatal depression include biological treatments such as antidepressant medication, electroconvulsive therapy, and light therapy, as well as psychosocial and lifestyle interventions such as psychotherapy and exercise (APA, 2010; Misri & Kendrick, 2007). The two treatments that have been most systematically studied and recommended in practice guidelines are antidepressant medication and psychotherapy (ACOG, 2008; APA, 2010; Howland, 2009; Pearlstein, 2008). In this section we review both treatments, but we highlight IPT in detail because it has the strongest evidence base for any psychosocial intervention.

Antidepressant Medication

The APA (2010) guidelines review the following types of antidepressant medications: tricyclic antidepressants (TCAs; e.g., Elavil, Tofranil), selective serotonin reuptake inhibitors (SSRIs; e.g., Prozac, Paxil, and Zoloft), serotonin-norepinephrine reuptake inhibitors (SSNRs; e.g., Effexor, Cymbalta), monoamine oxidase inhibitors (e.g., Parnate, Nardil), and other

antidepressants (e.g., Wellbutrin, Remeron). All are comparable in terms of effectiveness in treating depression in the general population but differ in terms of side effects. In this regard, SSRIs have emerged as the most commonly prescribed antidepressants primarily because they have a more favorable side-effect profile.

All psychotropic medications cross the placenta, and none are approved by the Federal Drug Administration (FDA) for use during pregnancy (ACOG, 2008). This is significant in that up to 9% of pregnant women have taken an antidepressant sometime during pregnancy (Pearlstein, 2008). The FDA uses the following five-category system for rating medications relative to fetal risk (Briggs, Freeman, & Yaffe, 1998): *A* (controlled studies show no fetal risk), *B* (no evidence of risk in humans), *C* (fetal risk cannot be ruled out), *D* (positive evidence of risk), and *X* (established risk to fetus outweighs any benefit). No psychotropic medication is rated *A*. Most antidepressants are rated *C* because there is insufficient study to rule out risk. The only antidepressants rated as *B* are Wellbutrin and Ludiomil.

Adverse effects of antidepressant exposure during pregnancy have been linked to the timing and duration of use as well as to dosage levels (Howland, 2009; Suri et al., 2007). Studies that have simply looked at effects at any time during pregnancy have found that antidepressant exposure is associated with younger gestational age and lower weight at birth (Pearlstein, 2008; Suri et al., 2007). In terms of specific time periods, first trimester use of Paxil has been linked to increased cardiac malformations in the baby (APA, 2010; Cole, Ephross, Cosmatos, & Walker, 2007), prompting the FDA to label Paxil with a *D* rating. Exposure to antidepressants during the second half of pregnancy is associated with increased incidence of pulmonary hypertension in newborns, which can be a serious complication (ACOG, 2008; APA, 2010; Chambers et al., 2006). Third trimester exposure to SSRIs (especially Paxil) and TCAs has been associated with increased risk of persistent pulmonary hypertension and premature birth (APA, 2010; Chambers et al., 2006; Dietz et al., 2007). A number of studies have documented that late SSRI exposure increases the risk of neonatal withdrawal syndrome characterized by jitteriness, sleep problems, mild respiratory distress, and weak cry (APA, 2010; Pearlstein, 2008; Sans, De-las-Cuevas, Kiuru, Bate, & Edwards, 2005). Furthermore, although few studies have looked at long-term effects on the child (APA, 2010), some evidence suggests slowed motor development during the 1st year (Pearlstein, 2008). These findings indicate that antidepressant exposure is associated with risk of complications to the infant, but data are limited with regard to long-term effects on children (ACOG, 2008).

Despite these risks, best practice guidelines recommend antidepressants for certain women during pregnancy. Guidelines indicate that pregnant women who are already taking maintenance medication should continue doing so, especially if they have a history of past recurrent episodes of depression (ACOG, 2008; APA, 2010; Freeman, 2007). Antidepressants are also recommended for women who have a history of depression, because the risk of relapse is high during pregnancy. At particularly high risk are those women who have had three or more previous depressive episodes and/or have depression that has lasted longer than 5 years (APA, 2010; Cohen et al., 2006). Generally, antidepressants are recommended for women whose MDD is in the moderate or severe range (APA, 2010). For these women, the guidelines assume that the risks of untreated maternal depression outweigh the risks associated with antidepressant exposure (APA, 2010; Parry, 2009). Guidelines also recommend that even when medication is used as a treatment option, it should be combined with psychotherapy to maximize treatment effectiveness and to minimize the necessary dose of the antidepressant (APA, 2010).

Psychotherapy

It is surprising that psychotherapy for PND has been a neglected area in both research and counseling practice. To date, most of the attention has been focused on the treatment of postpartum depression (Dennis & Hodnett, 2007). The few controlled studies examining the use of psychotherapy for PND (Dennis, Ross, & Grigoriadis, 2007; Pearlstein, 2008) suggest that both IPT and cognitive behavioral therapy (CBT) have the most evidence, with IPT being more extensively studied and supported (ACOG, 2008; APA, 2010; Bledsoe & Grote, 2006). In this section we review these studies, provide an overview of CBT, and outline the IPT treatment protocol.

CBT. Despite its effectiveness in treating major depression (APA, 2010; Roth & Fonagy, 2005), there are few trials examining the effectiveness of CBT for PND (McGregor, 2008). However, there is a solid line of studies demonstrating the effectiveness of CBT for postpartum depression (Chabrol, Teissedre, Armitage, Danel, & Walburg, 2004; Dennis & Hodnett, 2007; Seritan & Popescu, 2008). In contrast to this line of evidence, the few studies that have investigated CBT for PND have shown no statistical differences between CBT treatment and control groups (Austin et al., 2008; McGregor, 2008; McKee, Zayas, Fletcher, Boyd, & Nam, 2006). Even though there is a lack of solid research support, best practice guidelines recommend CBT as a viable treatment option for PND based on this postpartum evidence (APA, 2010).

CBT may be beneficial for pregnant women because the approach focuses on (a) encouraging women to examine patterns of thinking about pregnancy and impending motherhood and how these might be affecting their mood; (b) encouraging the expression of negative thoughts and feelings and facilitating acknowledgment of any maternal ambivalence; (c) challenging the "shoulds" that may be connected to ideas about "perfect" pregnancy or motherhood; and (d) enhancing women's awareness of their physiological reactions to their depressive symptoms, which may be helpful to distinguish pregnancy-related changes from depression.

These goals can be accomplished by using CBT intervention components such as psychoeducation about depres-

sion; goal setting, monitoring, and increasing pleasurable activities; implementing cognitive restructuring techniques to help clients recognize the interconnectedness between thoughts, feelings, and behaviors; and identifying and challenging irrational or negative thoughts to replace them with more balanced thinking. Counselors may also teach skills for stress reduction, communication skills, assertiveness skills, problem-solving strategies, and techniques for developing stronger support networks (Austin et al., 2008; Cho, Jung, & Lee, 2008; McGregor, 2008).

IPT. IPT is a time-limited, semistructured therapy originally designed for the treatment of depression (Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman, Markowitz, & Klerman, 2000). IPT assumes that depression occurs in an interpersonal context and helps the client to relieve depressive symptoms and to cope better with the interpersonal problems associated with symptom onset. Interpersonal issues are highly relevant to pregnant women as they manage relational changes and multiple transitions in identity, family, work, and societal roles (Cyranowski & Frank, 2006; Spinelli, 1999).

Because of its relevance in this area, IPT has been tailored to meet the specific needs of pregnant women. Interpersonal therapy for pregnancy (IPT-P) is a 16-session, manualized form of IPT developed by Spinelli (1999). In a randomized controlled trial of depressed pregnant women from primarily low-income and diverse racial/ethnic backgrounds, women who received IPT-P demonstrated significantly reduced depression symptoms compared with a control group. The IPT-P group showed a recovery rate of 60%, whereas the control group showed a recovery rate of only 15% (Spinelli & Endicott, 2003).

Another adaptation of IPT for PND is IPT-Brief (IPT-B; Grote, Bledsoe, Swartz, & Frank, 2004), which is an 8-week treatment program. Grote et al. (2007) conducted a randomized controlled trial comparing IPT-B with usual care provided by an OB/GYN clinic and found that compared with the control group, participants in IPT-B group displayed significant reductions in depression before childbirth and at follow-up. These two forms of IPT are reviewed in the paragraphs to follow.

IPT-P. The IPT-P treatment manual as developed by Spinelli (1999) outlines treatment as unfolding through a pretreatment assessment (1 session) and three phases (16 sessions). In the pretreatment assessment, the counselor determines the appropriateness of treatment by reviewing depressive symptoms, working to distinguish symptoms of depression from symptoms of normal pregnancy (as outlined in the previous section on screening and diagnosis). During the pretreatment assessment, it is also necessary to ask the client about the feasibility of treatment; in many cases counselors will need to be flexible in their provision of services, being willing to provide phone consultations and hospital visits or to allow the infant or young children to attend sessions.

As therapy begins, the initial phase consists of one or two sessions during which the following tasks are accomplished: (a) The counselor and client conduct an interpersonal inventory, (b) they collaboratively identify one or two interpersonal problem areas on which to focus, and (c) they develop a treatment contract. To conduct an interpersonal inventory, the counselor collects information about significant relationships in the client's life as she describes her interactions with and expectations for each relationship (Weissman, Markowitz, & Klerman, 2007). In addition to information about significant relationships, the counselor should also collect information about the client's feelings regarding her pregnancy and her reproductive history (i.e., previous miscarriages, abortions, or difficulties in becoming pregnant).

On the basis of this inventory, the client and counselor identify one or two interpersonal problem areas that will be the focus of treatment. These areas include grief, role disputes, role transitions, interpersonal deficits, and conflicted/complicated pregnancy. These are described in the remainder of this subsection. As the counselor identifies the client's specific interpersonal problem areas, the counselor can assist her in understanding how the depressive symptoms might have developed as a way to cope with these difficulties (Weissman et al., 2007). A treatment plan can then be developed based on this formulation, including specific target goals and steps the client can make to improve her relationships.

The working phase of IPT-P is an active phase in which the client is encouraged to discuss issues related to her identified problem areas and to focus on her feelings associated with these problems. As identified in the treatment plan, therapy sessions will center primarily on making changes related to the identified interpersonal problem areas.

Grief is relevant in treatment when the client is experiencing problems related to the loss or death of a significant other, which could include a previous miscarriage, abortion, loss of another child, or loss of her partner or the baby's father. Because the woman is preoccupied with the new baby, she might experience a delayed or distorted grief reaction, leading to an incomplete mourning over the loss. The first step in IPT-P grief work is to assist the client in connecting the loss with the onset or increase of depressive symptoms. Once this link is made, the client is encouraged to actively mourn the loss by thinking about and describing it in detail. Next, she can fully explore her feelings about the relationship and the loss in the present. It is especially helpful for her to create a realistic picture of the relationship, recalling both the good and bad qualities, because exploring a balanced view of a lost relationship helps to facilitate the mourning process (Weissman et al., 2000). Finally, she can examine the need for strengthening existing relationships or establishing a new social network that will provide support.

Role disputes are a relevant area when the client and significant others have conflicting expectations in their relationship. Such interpersonal conflict can cause a pregnant woman to feel powerless and out of control, resulting in depression. To address disputes, the counselor can first determine the stage

of the dispute: negotiation (ongoing attempts to improve the relationship), impasse (neither individual is attempting to change), or dissolution (the relationship is beyond repair). The client can then decide if she needs to repair the relationship or to make a decision to end the relationship.

A third potential interpersonal area is *role transitions.* Pregnant women who are depressed are likely to experience problems with role transitions, given the major role adjustments that occur with the birth of a child and in becoming a mother, such as the loss of individual identity, independence, and freedom; career transitions; physiological changes and body image concerns associated with pregnancy (particularly for women who place a high value on having a thin body and appearance as part of self-worth); and changes associated with managing new responsibilities as a parent.

To successfully resolve role transitions, the counselor will first help the client to explore and validate her perceived losses regarding the former role and to explore her anxiety and ambivalence about the new role. By encouraging the client to express her feelings around the loss, the client can begin to work through her feelings of anger and ambivalence and ultimately learn to mourn her perceived losses. The counselor can also help the client develop a more balanced perspective by recognizing that she does not have to give up all aspects of her former role; the client can begin to discover ways to maintain her former goals or identity that permit some feelings of control. She may also benefit from acquiring new skills to develop a sense of mastery regarding the demands of motherhood. Not only might she need to learn basic parenting skills, but she will also need strategies for managing multiple life demands simultaneously.

Interpersonal deficits are a problem area that is likely to occur in women with a history of social isolation and few meaningful relationships (Weissman et al., 2000). As originally defined in the IPT manual (Klerman et al., 1984), clients with interpersonal deficits may have few friends, limited contact with their families, or a history of repeated relationship failures. The counselor can help the client to minimize her social isolation, review problems that occurred in her previous relationships and in her parental relationship, and explore how these experiences contributed to her pattern of difficult interactions with others. By focusing on the counselor–client relationship, the client can learn appropriate ways to express her feelings about the counselor and to relate these to problems she has experienced in other relationships. She may also need basic problem-solving and parenting skills, possibly role playing ways of interacting with significant others and with her baby.

The fifth IPT-P problem area identified in the IPT-P manual is *conflicted and/or complicated pregnancy*. A conflicted pregnancy can occur from such circumstances as an unplanned or untimely pregnancy at a very young age (when the mother must cope with an interrupted adolescence) or at an older age (when the mother is concerned with interruptions in her career and overall lifestyle or has fears surrounding the increased risk of birth defects in her child). An overvalued pregnancy might occur after a client has had great difficulty in conceiving or in carrying a child to term. She might have experienced multiple miscarriages and/or fertility treatments, resulting in years of vacillation between hope and bereavement. During her current pregnancy, she may continue to experience ambivalence as she feels elated about the pregnancy but also detached as a way to protect herself against another painful loss. Conflicted pregnancies can also encompass problems related to the father of the child in the case of rape or incest.

A complicated pregnancy can arise when the mother experiences obstetrical difficulties such as gestational diabetes or is diagnosed with a concurrent medical condition. A final problem that can complicate pregnancy is when the mother learns of fetal anomalies in her unborn child. This news can be emotionally devastating to a mother and her family, and in counseling she can learn to accept the loss of her desired pregnancy and begin to adapt to the idea of her new life as a parent of a child with special needs (Spinelli, 1999; Weissman et al., 2000).

The termination phase of IPT-P, generally lasting four sessions, can be difficult for clients. During termination, the client should be given adequate opportunities to process her feelings regarding the end of the counseling relationship, grieving any feelings of loss she may be experiencing. She should also be given an opportunity to consolidate her learning from the counseling process and be commended for the specific progress she has made toward her goals. The counselor should also assist the client in identifying areas in which continued improvements are needed and to help her develop a plan for needed action steps she can take that are reasonable given the forthcoming demands of delivery and caring for an infant.

IPT-Brief. Grote et al. (2004; 2007) designed IPT-B to be brief in duration (eight sessions) and to be as convenient as possible (conducted in conjunction with routine obstetrical care). Although both IPT-P and IPT-B have demonstrated effectiveness for women from diverse racial/ethnic backgrounds, IPT-B is intentionally structured to be culturally consonant with the worldviews of diverse minority groups. To this end, traditional IPT is enhanced in three ways: conducting an engagement session, providing individualized psychoeducation, and providing flexibility that respects the pregnant woman's particular life circumstances.

In the initial engagement session, the counselor works to engage the client in the counseling process as the counselor seeks to understand her cultural perspectives and values. The client is asked about her view of the depression, the social problems she faces, any practical and psychological barriers she experiences that might block access to services, her attitudes toward mental health services in general, and her health-related beliefs and coping practices, including the importance of spirituality and prayer in her life. She is also asked specifically about her expectations for counseling and the qualities she is looking for in a counselor. Throughout this

line of questioning, her strengths are emphasized. Next, in addition to working to resolve identified IPT problem areas, the counselor provides the client with individualized psychoeducation so that the counselor can respond to her specific needs, which might include assisting her in accessing social services. The third aspect of IPT-B is the level of flexibility built into the provision of treatment. Sessions are held at the OB/GYN clinic where she already receives prenatal medical care and are scheduled around her visits to the clinic. Clients are compensated for attending sessions and receive additional funds to ensure their attendance, including bus passes and child care (Grote et al., 2007).

Recommendations regarding the use of psychotherapy. The best practice guidelines for PND recommend that psychotherapy should be strongly considered as a first-line treatment when depression is in the mild to moderate range, especially if the woman has experienced good response to psychotherapy in the past or strongly prefers to avoid medication (ACOG, 2008; APA, 2010; Dietz et al., 2007; Pearlstein, 2008). Psychotherapy is also recommended for more severe depression in combination with antidepressants. The obvious advantage of psychotherapy is that it affords the benefits of treating depression without the risks associated with antidepressant exposure (APA, 2010). In the general adult population, there is also evidence that psychotherapy effects may persist longer and lengthen the time between episodes in comparison with antidepressants (Roth & Fonagy, 2005). However, it is unknown if this effect is also evident in pregnant women.

Research indicates that most pregnant women would choose psychotherapy over medication when they are offered a choice (Chabrol et al., 2004; Goodman, 2009). For example, Goodman (2009) found that 92% of her sample of pregnant women rated psychotherapy as their top treatment option for depression, in comparison with only 7% of women who selected antidepressants. Pregnant women are also amenable to psychotherapy during pregnancy because they see it as an ideal time to make changes in their lives to improve their mental health before the baby is born (Cyranowski & Frank, 2006; Moses-Kolko & Ross, 2004). In addition, as emphasized in the previous subsections on CBT and IPT, psychotherapy is an opportunity for women to learn skills and to utilize support resources that will persist into the postpartum period, which may prevent the development of postpartum depression (Dennis et al., 2007).

Despite the many benefits of psychotherapy, it does require time and effort to yield positive effects (APA, 2010; Roth & Fonagy, 2005). The nature and demands of pregnancy as well as economic considerations may make it difficult for women to participate in regular counseling. For example, Goodman (2009) reported that a high percentage of her sample of pregnant women indicated that no time (65%), stigma associated with treatment (43%), and lack of child care (33%) were significant barriers to utilizing treatment. In another sample, women preferred to wait and get over the depression rather than seek active treatments such as counseling or antidepressants (Sleath et al., 2005). Counselors, therefore, should be sensitive to client issues such as severity of depression, motivation, preference, stigma associated with treatment, and potential life barriers.

Discussion

Approximately 1 in 5 women are depressed at some point during pregnancy (Dietz et al., 2007; Gavin et al., 2005), with about 1 in 10 having major depressive episodes (Bennett et al., 2004; J. Evans et al., 2001). Medications are often recommended for women who present with depressive symptoms, as untreated PND is associated with inadequate prenatal care, adverse health consequences to the unborn child, postpartum complications such as increased depression risk for the mother, and cognitive and behavioral problems for the child (Halbreich, 2004; Pearlstein, 2008; Van den Bergh et al., 2005).

However, research is largely inconclusive about the risks of antidepressants to the baby. Despite the fairly strong endorsement of antidepressants by the medical community, it should be noted that no randomized controlled trials of efficacy for treating MDD during pregnancy have ever been done (APA, 2010). Furthermore, none of the medications are rated as *A* (no fetal risk), and most are rated *C* (insufficient study to rule out risk). In addition, no psychotropic medications are approved for use during pregnancy by the FDA (ACOG, 2008). Therefore, the recommendations made by leading medical associations are primarily based on clinical consensus in the absence of clear positive findings.

Because of the prevalence of PND and its potential negative effects, counselors can play an important role both in the provision of treatment and in serving as advocates for women regarding this issue. Counselors who work with women experiencing PND should be familiar with effective treatments, particularly IPT-P and IPT-B, as these are the best studied and most supported in research trials. Both IPT-P and IPT-B are uniquely tailored to address the needs of pregnant women.They recognize the importance of relationships in women's lives, respect the major life transitions that occur with pregnancy and motherhood, and address the reality of physical and psychological barriers to treatment for many women. Both treatments are also designed to address feasibility issues by coordinating psychotherapy with regularly scheduled prenatal care as well as providing such flexibility as telephone sessions, providing child care, and inviting mothers to bring newborns or young children to sessions. However, most counselor preparation programs do not provide training in IPT, and most practitioners are not familiar with IPT-P or IPT-B. To enable counselors to provide the most effective treatment for their clients, counselor educators can provide information to students about these approaches. Furthermore, practitioners can seek opportunities to gain more knowledge

and experience in using the IPT approach with their clients who experience depression during pregnancy.

Because of the negative impact of PND on pregnant women and on low-income, minority, and single mothers in particular (Pearlstein, 2008), a second role in which counselors can serve is as an advocate for women. Using the ACA Advocacy Competencies (Lewis, Arnold, House, & Toporek, 2002; Toporek, Lewis, & Crethar, 2009) as a guide, counselors can advocate within four domains. First, at the *client empowerment domain*, counselors can encourage the client's participation in making her own decisions and assist her in making informed choices about treatment options. Due in part to sociocultural influences that devalue women's roles in general and motherhood in particular (Eriksen & Kress, 2008; K. M. Evans, Kincade, Marbley, & Seem, 2005), pregnant women may experience feelings of powerlessness. Counselors can help to restore the client's sense of personal power, providing her with the necessary support and information she needs to make these important decisions for herself and for the future of her child (Eriksen & Kress, 2008). Counselors should also consider a client's cultural context in understanding her response to treatment options. For example, women from diverse backgrounds may be reluctant to take antidepressants or other psychotropic medication during pregnancy (Chabrol et al., 2004; Goodman, 2009; Sleath et al., 2005), and counselors should fully explore with clients any existing barriers to medical care or treatment.

Second, the ACA Advocacy Competencies call for advocating on behalf of clients when necessary (*client advocacy domain;* Ratts & Hutchins, 2009). Counselors are in a position to facilitate the client's decision-making process by consulting with health care providers (including the obstetrician) as well as other significant parties such as the partner, the baby's father, or other family members (ACOG, 2008; Freeman, 2007). Counselors can advocate for a woman when they respect her right to make decisions, while also helping her to recognize when she needs assistance from her support system. For example, counselors should be aware that if the woman's depression is in the severe range, this can complicate her decision-making ability (Wisner et al., 2009) and require more input from these other sources. Counselors can also serve as advocates in assisting their clients in obtaining access to needed resources such as social services, a strategy utilized in IPT-B (Grote et al., 2007). This is essential as pregnant women may need additional resources such as prenatal care or parenting education and support.

Third, counselors can work at the *community collaboration/ systems advocacy domain*. As advocates, counselors can be proactive in educating the medical community about the importance of screening for PND and for recommending appropriate treatment options. Counselors can also collaborate with medical and mental health professionals to ensure that appropriate services are accessible and available to women. They can also increase awareness of the important role that psychotherapy serves in women's treatment.

Finally, counselors can advocate at the *public domain* by providing public information about the symptoms of PND, the adverse outcomes associated with untreated depression, and the potential risks of medications. Education can also include information and referral sources for counseling services in the community. Most important, as social justice advocates, counselors can work to change conditions that contribute to the onset of depression in pregnant women, including problems related to poverty and the systemic oppression of women (Eriksen & Kress, 2008; Lopez-Baez & Paylo, 2009).

In conclusion, counseling pregnant women with depression can be challenging, but it can also yield substantial benefits for the mother and her child. Counselors can be prepared to provide effective treatments and become more knowledgeable of best practice treatment approaches for PND. In their role as advocates, counselors can also assist women in making informed choices about their treatment, serve as consultants to health care providers and family members, and advocate for women's increased access to both information and effective treatment for prenatal depression.

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