



Comparative Effectiveness Review
Number 271

Nonpharmacologic Treatments for Maternal Mental Health Conditions



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Drs. Alex Peahl and Margaret Howard have financial conflicts of interest, neither of which are related to the nonpharmacologic care of perinatal mental health disorders. Dr. Margaret Howard has published studies relevant to perinatal mental health. As a result, they did not participate in screening or determination of studies to be included in the systematic review, assessing risk of bias in studies, extracting data from studies, or grading the strength of evidence. None of the other investigators have any affiliations or financial involvement that conflicts with the material presented in this report.

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Preface

The Agency for Healthcare Research and Quality (AHRQ), through its Evidence-based Practice Centers (EPCs), sponsors the development of systematic reviews to assist public- and private-sector organizations in their efforts to improve the quality of healthcare in the United States. These reviews provide comprehensive, science-based information on common, costly medical conditions, and new healthcare technologies and strategies.

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If you have comments on this systematic review, they may be sent by mail to the Task Order Officer named below at: Agency for Healthcare Research and Quality, 5600 Fishers Lane, Rockville, MD 20857, or by email to epc@ahrq.hhs.gov.

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Key Informants

In designing the study questions, the EPC consulted several Key Informants who represent the end-users of research. The EPC sought the Key Informant input on the priority areas for research and synthesis. Key Informants are not involved in the analysis of the evidence or the writing of the report. Therefore, in the end, study questions, design, methodological approaches, and/or conclusions do not necessarily represent the views of individual Key Informants.

Key Informants must disclose any financial conflicts of interest greater than \$5,000 and any other relevant business or professional conflicts of interest. Because of their role as end-users, individuals with potential conflicts may be retained. The TOO and the EPC work to balance, manage, or mitigate any conflicts of interest.

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In designing the study questions and methodology at the outset of this report, the EPC consulted several technical and content experts. Broad expertise and perspectives were sought.

Divergent and conflicted opinions are common and perceived as healthy scientific discourse that results in a thoughtful, relevant systematic review. Therefore, in the end, study questions, design, methodologic approaches, and/or conclusions do not necessarily represent the views of individual technical and content experts.

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Nonpharmacologic Treatments for Maternal Mental Health Conditions

Abstract

Objectives. This systematic review evaluates nonpharmacologic treatments for mental health conditions during the perinatal period (pregnancy and up to 12 months postpartum). We evaluated nonpharmacologic treatments for perinatal individuals with depressive disorders, anxiety disorders, bipolar disorder, post-traumatic stress disorder (PTSD), or obsessive-compulsive disorder (OCD).

Data sources and review methods. We searched MEDLINE®, PsycINFO®, Embase®, CINAHL®, the Cochrane Register of Clinical Trials, the Cochrane Database of Systematic Reviews, and ClinicalTrials.gov from January 1, 2000, to January 17, 2024, to identify relevant randomized controlled trials (RCTs). Nonpharmacologic interventions of interest included, among others, cognitive behavioral therapy (CBT), interpersonal therapy (IPT), exercise, non-directive counseling, behavioral activation, bright light therapy, eye movement desensitization and reprocessing (EMDR), and acupuncture. Outcomes of interest were improvement in scores on psychological assessment tools, cure or resolution of symptoms, suicide-related outcomes, and adherence to treatment. PROSPERO registration number: CRD42023440650.

Results. We identified 103 RCTs. Nonpharmacologic treatments were compared to control or each other in 101 RCTs and to pharmacologic treatments in 2 RCTs. The risk of bias was moderate for the majority of included studies, mostly related to lack of blinding. For perinatal individuals with depressive disorders, CBT was more effective than treatment as usual (TAU) to reduce depressive and anxiety symptoms (both moderate strength of evidence [SoE]); IPT was more effective than TAU to treat depressive symptoms (moderate SoE) and anxiety symptoms (low SoE); and both behavioral activation (a CBT technique, with low SoE) and exercise interventions (moderate SoE) were more effective than TAU to reduce depressive symptoms. Remission rates for depressive symptoms were higher with CBT and IPT compared to TAU (both low SoE) and higher with specific acupuncture than nonspecific or sham acupuncture (low SoE). There were no differences between CBT and non-directive counseling (an active patient-led intervention), between counseling and TAU, and between bright light and placebo light therapy (all low SoE). CBT was more effective than TAU to reduce anxiety and depressive symptoms for individuals with combined depressive and anxiety disorders (low SoE). Few (or no) eligible studies evaluated individuals with anxiety disorder, PTSD, OCD, or bipolar disorders, precluding conclusions for these conditions. There was also insufficient evidence for suicide-related outcomes, potential harms of treatment, and adherence to treatment, and for comparisons of nonpharmacologic with pharmacologic treatments.

Conclusion. Several nonpharmacologic treatments are more effective than TAU for perinatal mental health conditions, with the strongest evidence for CBT and IPT to reduce depressive symptoms among perinatal individuals with depressive disorders or combined depressive and anxiety disorders. Future research is needed to evaluate the comparative effectiveness of lesser studied nonpharmacologic interventions and lesser studied perinatal mental health conditions.

Contents

Executive Summary	ES-1
1. Introduction.....	1
1.1 Background.....	1
1.2 Purpose of This Review	2
2. Methods.....	3
2.1 Review Approach.....	3
2.2 Key Questions.....	3
2.3 Analytic Framework	4
2.4 Literature Search.....	5
2.5 Study Eligibility.....	6
2.5.1 Population	7
2.5.2 Intervention/Comparator.....	7
2.5.3 Outcomes	8
2.6 Screening Studies for Eligibility	9
2.7 Data Extraction and Management.....	10
2.7.1 Classification of Studies for Full Data Synthesis or Appendix Evidence Map	10
2.7.2 Extraction and Management for Studies Meeting Criteria for Full Data Synthesis	11
2.8 Intervention Coding	11
2.8.1 Acupuncture.....	11
2.8.2 Behavioral Activation	12
2.8.3 Bright Light Therapy	12
2.8.4 Cognitive Behavioral Therapy.....	12
2.8.5 Exercise.....	12
2.8.6 Eye Movement Desensitization and Reprocessing Therapy.....	12
2.8.7 Interpersonal Therapy	12
2.8.8 Non-Directive Counseling	13
2.8.9 Psychoeducational Interventions	13
2.8.10 Yoga.....	13
2.8.11 Treatment as Usual	13
2.8.12 Delivery Characteristics.....	13
2.9 Assessment of Risk of Bias in Individual Studies	14
2.10 Data Synthesis.....	14
2.11 Grading the Strength of Evidence for Major Comparisons and Outcomes	14
2.12 Assessing Applicability	15
2.13 Peer Review and Public Commentary	15
3. Results	16
3.1 Literature Search Results.....	16
3.2 Description of Included Evidence.....	17
3.3 KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments	18
3.3.1 KQ 1: Key Points.....	19
3.3.2 KQ 1: Nonpharmacologic Treatments for Depressive Disorders	20
3.3.3 KQ 1: Nonpharmacologic Treatments for Anxiety Disorders.....	67
3.3.4 KQ 1: Nonpharmacologic Treatments for Depressive and Anxiety Disorders	71
3.3.5 KQ 1: Nonpharmacologic Treatments for Depressive and/or Anxiety Disorders	76
3.3.6 KQ 1: Nonpharmacologic Treatments for PTSD.....	80

3.3.7 KQ 1: Nonpharmacologic Treatments for OCD.....	87
3.3.8 Nonpharmacologic Treatments for Bipolar Disorder	88
3.4 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments	88
3.4.1 Key Points.....	88
3.4.2 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for Depressive Disorders	88
3.4.3 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for Anxiety Disorders	89
3.4.4 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for PTSD	89
3.4.5 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for OCD.....	89
3.4.6 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for Bipolar Disorder ..	89
4. Discussion.....	90
4.1 Key Findings	90
4.2 Findings in Relation to What Is Already Known.....	94
4.2.1 KQ 1: Nonpharmacologic Treatments for Depressive Disorders	94
4.2.2 KQ 1: Nonpharmacologic Treatments for Anxiety Disorders	95
4.2.3 KQ 1: Nonpharmacologic Treatments for Depressive and/or Anxiety Disorders	95
4.2.4 KQ 1: Nonpharmacologic Treatments for PTSD.....	95
4.2.5 KQ 1: Nonpharmacologic Treatments for OCD.....	96
4.2.6 KQ 1: Nonpharmacologic Treatments for Bipolar Disorder	96
4.2.7 KQ 2: Nonpharmacologic Compared With Pharmacologic Treatment for Perinatal Mental Health Conditions	96
4.3 Applicability	96
4.4 Strengths and Limitations	97
4.4.1 Strengths and Limitations of the Systematic Review Process	97
4.4.2 Strengths and Limitations of the Evidence Base	98
4.5 Implications for Clinical and Policy Decision Making.....	99
4.6 Implications for Research	100
4.7 Conclusions.....	101
References.....	102
Abbreviations and Acronyms	115

Tables

Table A. Summary of nonpharmacologic treatments for depressive or anxiety disorders	3
Table 1. Inclusion and exclusion criteria	6
Table 2. Number of studies extracted fully and extracted to the evidence map by Key Question 17	
Table 3. KQ 1: Number of studies that met criteria for full extraction by perinatal mental health disorder and intervention comparisons	19
Table 4. KQ 1: Strength of evidence of nonpharmacologic treatments for depressive disorders	21
Table 5. Specific versus non-specific acupuncture for depressive disorders: Description of interventions and comparisons.....	23
Table 6. Behavioral activation versus placebo light therapy for depressive disorders: Description of interventions and comparisons	27
Table 7. Bright light therapy versus placebo light therapy for depressive disorders: description of interventions and comparisons.....	31
Table 8. CBT versus non-directive counseling for depressive disorders: Description of interventions and comparisons.....	33

Table 9. CBT versus TAU for depressive disorders: Description of interventions and comparisons	37
Table 10. CBT versus TAU for depressive disorders: Depressive symptoms by CBT delivery mode.....	45
Table 11. CBT versus TAU for depressive disorders: Depressive symptoms by delivery setting	45
Table 12. Counseling versus TAU for depressive disorders: Description of interventions and comparisons	51
Table 13. Exercise versus TAU for depressive disorders: Description of interventions and comparisons	55
Table 14. IPT versus TAU for depressive disorders: Description of interventions and comparisons	59
Table 15. IPT versus TAU for depressive disorders: Depressive symptoms by IPT delivery mode	64
Table 16. KQ 1: Strength of evidence of nonpharmacologic treatments for anxiety disorder	68
Table 17. Multicomponent intervention versus TAU for anxiety disorders: Description of interventions and comparisons.....	69
Table 18. CBT versus TAU for anxiety disorders: Description of interventions and comparisons	70
Table 19. KQ 1: Strength of evidence of nonpharmacologic treatments for depressive and anxiety disorders.....	72
Table 20. Yoga and tai chi versus TAU for depressive and anxiety disorders: Description of interventions and comparisons.....	73
Table 21. CBT versus TAU for depressive and anxiety disorders: Description of interventions and comparisons.....	74
Table 22. KQ 1: Strength of evidence of nonpharmacologic treatments for depressive or anxiety disorders.....	77
Table 23. CBT versus TAU for depressive or anxiety disorders: Description of interventions and comparisons	78
Table 24. KQ 1: Strength of evidence of nonpharmacologic treatments for PTSD	81
Table 25. CBT versus TAU for PTSD: Description of interventions and comparisons.....	82
Table 26. EMDR versus TAU for PTSD: Description of interventions and comparisons	84
Table 27. CBT versus TAU for PTSD: Description of interventions and comparisons.....	85
Table 28. Counseling versus TAU for PTSD: Description of interventions and comparisons	86
Table 29. KQ 1: Strength of evidence of nonpharmacologic treatments for OCD.....	87
Table 30. CBT versus TAU for OCD: Description of interventions and comparisons	87
Table 31. KQ 1: Summary of nonpharmacologic treatments for depressive or anxiety disorders by treatment type.....	91

Figures

Figure 1. Analytic framework for Key Questions 1 and 2: Nonpharmacologic interventions for mental health conditions in perinatal individuals	5
Figure 2. Literature flow diagram	16
Figure 3. Specific versus nonspecific acupuncture for depressive disorders: Remission.....	24
Figure 4. Specific versus nonspecific acupuncture for depressive disorders: Response	25
Figure 5. Behavioral activation versus TAU for depressive disorders: Depressive symptoms....	29

Figure 6. Bright light therapy versus placebo light therapy for depressive disorders: Depressive symptoms	32
Figure 7. CBT versus counseling for depressive disorders: Depressive symptoms at the end of treatment	34
Figure 8. CBT versus TAU for depressive disorders: Depressive symptoms at the end of treatment by diagnostic or screening tool used at enrollment.....	44
Figure 9. CBT versus TAU for depressive disorders: Remission of depressive symptoms at the end of treatment	46
Figure 10. CBT versus TAU for depressive disorders: Remission of anxiety symptoms at the end of treatment	46
Figure 11. CBT versus TAU for depressive disorders: Quality of life (EQ-5D).....	47
Figure 12. CBT versus TAU for depressive disorders: Availability of social support.....	48
Figure 13. CBT versus TAU for depressive disorders: PBQ impaired bonding at the end of treatment	49
Figure 14. CBT versus TAU for depressive disorders: PBQ infant anxiety at the end of treatment	49
Figure 15. CBT versus TAU for depressive disorders: PBQ rejection/anger at the end of treatment	50
Figure 16. Counseling versus TAU for depressive disorders: Depressive symptoms at the end of treatment	52
Figure 17. Exercise versus TAU for depressive disorders: Depressive symptoms at the end of treatment	56
Figure 18. IPT versus TAU for depressive disorders: Depressive symptoms at the end of treatment	63
Figure 19. IPT versus TAU for depressive disorders: Remission of depressive symptoms at the end of treatment or followup.....	64
Figure 20. IPT versus TAU for depressive disorders: Anxiety symptoms at the end of treatment	65
Figure 21. CBT versus TAU for depressive and anxiety disorders: Depressive symptoms at the end of treatment	75
Figure 22. CBT versus TAU for depressive and anxiety disorders: Anxiety symptoms at the end of treatment	76
Figure 23. CBT versus TAU for depressive or anxiety disorders: Depressive symptoms at the end of treatment	79
Figure 24. CBT versus TAU for depressive or anxiety disorders: Anxiety symptoms at the end of treatment	79

Appendixes

Appendix A. Methods

Appendix B. Excluded Studies

Appendix C. Evidence Map Tables, Study Design, and Baseline Tables

Appendix D. Outcomes

Appendix E. Risk of Bias Tables

Appendix F. Results Tables

Executive Summary

Main Points

- **Nonpharmacologic treatments for depressive disorders in perinatal individuals**
 - Cognitive behavioral therapy (CBT) is probably more effective than treatment as usual (TAU) to reduce depressive symptoms (moderate strength of evidence [SoE]) and anxiety symptoms (moderate SoE), and may increase rates of remission for depressive symptoms (low SoE).
 - Interpersonal therapy (IPT) is probably more effective than TAU to reduce depressive symptoms (moderate SoE) and anxiety symptoms (low SoE), and may increase remission rates for depressive symptoms (low SoE).
 - Behavioral activation may be more effective than TAU to reduce depressive symptoms (low SoE).
 - Exercise interventions are probably more effective than TAU to reduce depressive symptoms (moderate SoE).
 - Specific acupuncture compared with nonspecific or sham acupuncture may increase remission rates for depressive symptoms (low SoE).
 - There was insufficient evidence to make conclusions regarding CBT compared to non-directive counseling, non-directive counseling compared to TAU, or bright light therapy compared to placebo light therapy.
- **Nonpharmacologic treatments for anxiety disorders**
 - There was insufficient evidence to make conclusions.
- **Nonpharmacologic treatment for combined depressive and anxiety disorders**
 - CBT may be more effective than TAU to reduce anxiety and depressive symptoms (low SoE).
 - We did not find studies assessing the potential harms of nonpharmacologic treatments for combined anxiety and depressive disorders
- **Nonpharmacologic treatment for perinatal individuals with depressive or anxiety disorders**
 - There was insufficient evidence to make conclusions due to imprecision.
- **Nonpharmacologic treatment for post-traumatic stress disorder (PTSD)**
 - There was insufficient evidence to make conclusions.
- **Nonpharmacologic treatment for obsessive-compulsive disorder (OCD)**
 - There was insufficient evidence to make conclusions.
- **Nonpharmacologic treatment for bipolar disorder**
 - We did not identify any studies evaluating the comparative effectiveness of nonpharmacologic treatments for bipolar disorder.
- **Nonpharmacologic versus pharmacologic treatments for perinatal mental health conditions**
 - There was insufficient evidence to make conclusions.
- **There was insufficient evidence to draw conclusions regarding the potential harms of nonpharmacologic treatments for perinatal individuals with mental health conditions.**

Background and Purpose

During the perinatal period (defined as pregnancy through 12 months postpartum) individuals may experience various mental health conditions such as depression, anxiety, post-traumatic stress disorder, bipolar disorder, and obsessive-compulsive disorder. Mental health experiences can range in severity, for example from transient postpartum low mood to a depressive episode to more persistent depression. Lack of treatment or undertreatment of perinatal mental health conditions can have profound and persistent effects on both the mother and the developing fetus and child. Evidence-based clinical practice guidelines are needed to help clinical decision makers decide whether nonpharmacologic treatments, either alone or in conjunction with pharmacologic treatments, should be offered to perinatal individuals experiencing mental health conditions. The purpose of this review is to inform future guidance for the treatment of mental health conditions during the perinatal period. This review addresses two Key Questions (KQs) for perinatal individuals with depressive disorders, anxiety disorders, bipolar disorder, PTSD, or OCD: comparisons of (1) nonpharmacologic treatments and (2) pharmacologic versus nonpharmacologic treatments.

Methods

We used methods consistent with those outlined in the Agency for Healthcare Research and Quality (AHRQ) Evidence-based Practice Center Program Methods Guidance (<https://effectivehealthcare.ahrq.gov/products/collections/ceer-methods-guide>). Our searches targeted randomized controlled trials (RCTs) from January 1, 2000, to January 17, 2024. For studies of individuals with depressive or anxiety disorders, data extraction and risk of bias assessment was limited to interventions and comparisons with three or more studies; for these conditions, comparisons with fewer studies are summarized in the appendix. We extracted study data into the Systematic Review Data Repository Plus (SRDR+; <https://srdplus.ahrq.gov>). We assessed the risk of bias and evaluated the strength of evidence using standard methods. Given the large body of evidence and numerous interventions and comparisons for nonpharmacologic treatments of depression and anxiety, and given time and resource constraints, we restricted full data synthesis mostly to comparisons with three or more studies. Other comparisons are summarized briefly. Outcomes of interest were scores on psychological assessment tools, cure or resolution of symptoms, suicide-related outcomes, and adherence to treatment. Where sufficient comparable studies were available, we conducted meta-analyses of relative risk (RR) for categorical outcomes and, because of the heterogeneity in tool measures, standardized mean differences for tool scores. Negative standardized mean differences (SMDs) suggest that the intervention reduced symptoms more than the comparator. In accordance with AHRQ guidance we have incorporated qualifying language regarding SoE when communicating conclusions. “Probably” is used for conclusion statements with moderate SoE and “may” for conclusion statements with low SoE. “Insufficient evidence” means that the eligible studies did not provide adequate evidence to form a conclusion, primarily due to sparseness of evidence. The PROSPERO protocol registration number is CRD42023440650.

Results

We identified 103 primary studies; 101 RCTs addressed KQ 1 (comparison of nonpharmacologic treatments) and 2 RCTs addressed KQ 2 (comparison of nonpharmacologic and pharmacologic treatments). Our overall findings, including SoE assessment, regarding the

effectiveness of nonpharmacologic treatments for which we were able to make conclusions are in Table A.

For **KQ 1**: We identified 71 studies (N = 8,889) that evaluated comparisons of nonpharmacologic treatments reported by at least three RCTs; 18 of these studies were conducted in the U.S.

For *depressive disorders*, 28 RCTs compared CBT with TAU. CBT was probably more effective than TAU to reduce depressive symptoms (SMD -0.56 , 95% confidence interval [CI] -0.69 to -0.42 , moderate SoE) and anxiety symptoms (SMD -0.55 , 95% CI -0.67 to -0.44 , moderate SoE) as rated by validated scales. The mean difference in depressive symptoms was equivalent to -1.71 points (95% CI -2.10 to -1.28) on the Edinburgh Postnatal Depression Scale (EPDS). The mean difference in anxiety symptoms was equivalent to -5.64 points (95% CI -7.07 to -4.30) on the State Trait Anxiety Inventory (STAI). Remission rates were higher in the CBT group compared with TAU (RR 1.73, 95% CI 1.33 to 2.26, low SoE).

Nine RCTs compared IPT with TAU. IPT was probably more effective to treat depressive symptoms (SMD -0.56 , 95% CI -0.89 to -0.22 , moderate SoE) and anxiety symptoms (SMD -0.73 , 95% CI -1.19 to -0.26 , low SoE) as rated by validated scales. The mean difference in depressive symptoms was equivalent to -1.80 points (95% CI -2.71 to -0.67) on the EPDS and the mean difference in anxiety symptoms was equivalent to -7.84 points (95% CI -12.19 to -2.15) on the STAI. Remission rates for depressive symptoms were significantly higher in the IPT group compared to TAU (RR 1.22, 95% CI 1.04 to 1.43, low SoE).

Six RCTs compared exercise interventions with TAU. Exercise was probably more effective to reduce depressive symptoms (SMD -0.41 , 95% CI -0.74 to -0.08 , moderate SoE). The mean difference in depressive symptoms was equivalent to -1.25 points (95% CI -2.26 to -0.24) on the EPDS.

Table A. Summary of nonpharmacologic treatments for depressive or anxiety disorders

Intervention	Population	Outcome	Conclusion Effect Size (95% CI)	Effect Size, Back- Transformed (95% CI)	SoE
CBT vs. TAU	Depressive disorders	Reduced anxiety symptoms	CBT more effective SMD -0.55 (-0.67 , -0.44)	STAI -5.64 (-7.07 , -4.30)	Moderate
	Depressive disorders	Reduced depressive symptoms	CBT more effective SMD -0.56 (-0.69 , -0.42)	EPDS -1.71 (-2.10 , -1.28)	Moderate
	Depressive disorders	Remission of depressive symptoms	CBT more effective RR 1.73 (1.33, 2.26)	N/A	Low
	Combined depressive and anxiety disorders	Reduced anxiety symptoms	CBT more effective SMD -0.68 (-0.92 , -0.43)	STAI -6.97 (-9.43 , -4.41)	Low
	Combined depressive and anxiety disorders	Reduced depressive symptoms	CBT more effective SMD -0.72 (-1.21 , -0.53)	EPDS -2.20 (-3.69 , 1.62)	Low
	Depressive or anxiety disorders	Reduced anxiety symptoms	No conclusions SMD -0.03 (-0.04 to 0.34)	STAI -0.31 (-0.41 , -3.48)	Insufficient evidence
	Depressive or anxiety disorders	Reduced depressive symptoms	No conclusions SMD 0.00 (-0.23 to 0.23)	EPDS 0.00 (-0.70 , 0.70)	Insufficient evidence

Intervention	Population	Outcome	Conclusion Effect Size (95% CI)	Effect Size, Back- Transformed (95% CI)	SoE
IPT vs. TAU	Depressive disorders	Reduced anxiety symptoms	IPT more effective SMD -0.73 (-1.19, -0.26)	STAI -7.84 (-12.19, -2.15)	Low
	Depressive disorders	Reduced depressive symptoms	IPT more effective SMD -0.56 (-0.89, -0.22)	EPDS -1.80 (-2.71, -0.67)	Moderate
	Depressive disorders	Remission of depressive symptoms	IPT more effective RR 1.22 (1.04, 1.43)	N/A	Low
Exercise vs. TAU	Depressive disorders	Reduced depressive symptoms	Exercise more effective SMD -0.41 (-0.74, -0.08)	EPDS -1.25 (-2.26, -0.24)	Moderate
Behavioral activation vs. TAU	Depressive disorders	Reduced depressive symptoms	Behavioral activation more effective SMD -0.50 (-0.68, -0.33)	EPDS -1.53 (-2.07, -1.01)	Low
Specific vs. nonspecific acupuncture	Depressive disorders	Remission of depressive symptoms	Specific acupuncture more effective RR 1.48 (1.00, 2.19)	N/A	Low
Counseling vs. TAU	Depressive disorders	Reduced depressive symptoms	No conclusions SMD -0.25 (-0.53, 0.02)	EPDS -0.76 (-1.62, 0.06)	Insufficient evidence
CBT vs. counseling	Depressive disorders	Reduced depressive symptoms	No conclusions SMD -0.16 (CI -0.44, 0.11)	EPDS -0.49 (-1.34, 0.34)	Insufficient evidence
Bright light therapy vs. placebo light therapy	Depressive disorders	Reduced depressive symptoms	No conclusions SMD -0.58 (-1.38, 0.23)	EPDS -1.53 (-2.07, -1.01)	Insufficient evidence

Abbreviations: CBT = cognitive behavioral therapy, CI = confidence interval, IPT = interpersonal therapy, RR = relative risk, SMD = standardized mean difference, SoE = strength of evidence, TAU = treatment as usual, EPDS = Edinburgh postnatal depression scale, STAI = state trait anxiety inventory, N/A = not applicable

Three studies compared behavioral activation with TAU. Behavioral activation may be more effective to reduce depressive symptoms than TAU (SMD -0.50, 95% CI -0.68 to -0.33, low SoE), equivalent to a mean difference of -1.53 (95% CI -2.07 to -1.01) on the EPDS.

Three studies compared acupuncture with nonspecific or sham acupuncture. Remission rates for depressive symptoms were higher among individuals who received specific acupuncture compared with nonspecific acupuncture (RR 1.48, 95% CI 1.00 to 2.19, low SoE).

Effect sizes were estimated for counseling compared with TAU, CBT compared with counseling and bright light compared with placebo light therapies. Effect sizes were non-significant and imprecise, therefore there was insufficient evidence for determining equivalence between the previously listed comparisons.

Three RCTs compared CBT with TAU for participants with combined *depressive and anxiety disorders*. CBT may be more effective in treating anxiety symptoms (SMD -0.68, 95% CI -0.92 to -0.43, low SoE) equivalent to a mean difference of -6.97 points (95% CI -9.43 to -4.41) on the STAI. CBT may be more effective than TAU to reduce depressive symptoms (SMD -0.72, 95% CI -1.21 to -0.53), equivalent to a mean difference of -2.20 points (95% CI -3.69 to -1.62) on the EPDS.

Three RCTs compared CBT with TAU for participants with *depressive and/or anxiety disorders*. There was insufficient evidence for determining equivalence in anxiety symptoms

between CBT and TAU (SMD -0.03 , 95% CI -0.04 to 0.34). Similarly, there was insufficient evidence for determining equivalence in depressive symptoms at the end of treatment (SMD 0.00 , 95% CI -0.23 to 0.23).

For *anxiety disorders*, we identified two RCTs, however due to heterogeneity in interventions we were unable to draw conclusions. For *PTSD*, we identified four RCTs, however due to heterogeneity in interventions and insufficient reporting of key outcome data we were unable to draw conclusions. For *OCD*, there was insufficient evidence available from one RCT. We did not identify any RCTs that evaluated nonpharmacologic treatments for individuals with *bipolar disorder*.

For **KQ 2**, there was insufficient evidence from two RCTs comparing nonpharmacologic with pharmacologic treatments for any perinatal mental health condition.

Limitations

Although we identified 71 RCTs that met criteria for full analysis (i.e., with at least 3 RCTs evaluating specific comparisons) for KQ 1, we were limited to drawing conclusions regarding the effectiveness of nonpharmacologic treatments during the perinatal period to those with depressive disorders. CBT was the most frequently tested nonpharmacologic treatment, with few studies available for less frequently tested interventions and perinatal populations. There was considerable variation in how studies named, defined and reported nonpharmacologic treatments, making it challenging to determine if interventions could be meaningfully combined or compared. Very little data were available for exploring potential modifiers of treatment effect. Studies were inconsistent in the reporting of full outcome data, which limited our ability to include studies with insufficient reporting in our analyses. Many prioritized outcomes were either not reported in any included study for specific comparisons or were reported in an insufficient number of studies to allow meta-analyses or merit conclusions.

Implications and Conclusions

There is evidence for the effectiveness of nonpharmacologic treatment compared with treatment as usual for certain perinatal mental health conditions. The strongest empirical evidence was identified for CBT and IPT treatments for depressive conditions. However, other nonpharmacologic treatments, such as behavioral activation, exercise and acupuncture, and treatments of other mental health conditions have been infrequently evaluated in RCTs of perinatal individuals. Thus, it is unclear whether other treatments are also effective or what the comparative effectiveness is of CBT or IPT with other treatments (including pharmacologic treatments). The strongest evidence was available for the individuals with depressive disorders, future research is needed to assess the effectiveness of nonpharmacologic interventions for perinatal anxiety disorders (including bipolar disorder, PTSD, and OCD). There is also little evidence regarding prioritized outcomes other than depressive symptoms, anxiety, symptoms, and in some instances remission of symptoms. To further guide clinical and policy decision-making, future methodologically rigorous research is needed to evaluate the comparative effectiveness of lesser studied nonpharmacologic interventions and lesser studied perinatal mental health disorders.

1. Introduction

1.1 Background

During the perinatal period (defined as pregnancy through 12 months postpartum) individuals may experience various mental health conditions such as depression, anxiety, post-traumatic stress disorder (PTSD), bipolar disorder, and obsessive-compulsive disorder (OCD). Mental health experiences can range in severity, for example from transient postpartum low mood to a depressive episode to more persistent depression. Approximately 19 percent of individuals who were pregnant experience a depressive episode in the first 3 months postpartum, and about 7 to 13 percent experience depression during the perinatal period.¹ In the United States, the prevalence of postpartum depression varies across geographical regions (e.g., 10% in Illinois versus 24% in Mississippi) and tends to be higher in people who are under 19 years old, from minority ethnocultural groups, smoked during pregnancy, experienced various traumas, and self-reported depression before or during pregnancy.¹ Similarly, up to 20 percent of perinatal individuals meet criteria for an anxiety disorder,² 5 percent may experience perinatal PTSD,³ and 20 percent may experience bipolar-spectrum mood disorders.⁴ Prevalence of perinatal OCD is less clearly established, but a recent well-controlled study estimated prevalence of 8 percent during pregnancy and 17 percent postpartum.⁵ Of concern, the prevalence of perinatal mental health conditions has increased during the COVID-19 pandemic.⁶

There are significant health disparities in both the recognition and treatment of perinatal mental health disorders. Black pregnant individuals are less likely to be screened for mental health symptoms compared to white individuals.^{7, 8} Furthermore, people from minoritized groups (Black, Hispanic, Asian, Native American or Pacific Islander) have lower rates of referrals for perinatal mental health treatments, but have similar rates of treatment initiation compared to Non-Hispanic, White individuals.⁹ Lack of treatment or undertreatment of perinatal mental health conditions can have profound and persistent effects on both the mother and the developing fetus and child.¹⁰ Compared with non-depressed pregnant people, those who are depressed are more likely to smoke,¹¹ use alcohol,¹² and have inadequate gestational weight gain¹³ and are less likely to form an attachment to the fetus during the third trimester.¹⁴ Pregnant people who are both depressed and experiencing domestic violence are at particularly high risk for missing prenatal appointments.¹⁵ Depression during pregnancy is also associated with adverse pregnancy outcomes, such as preterm birth, low birth weight, operative deliveries, poorer postpartum pain control, opioid use, and longer pre-delivery hospital stays.^{16, 17} Individuals with postpartum depression are more likely than those without depression to have impaired bonding,^{18, 19} less likely to be fully responsive to infants' needs,^{19, 20} less likely to initiate or maintain breastfeeding,²¹⁻²⁴ and have a greater frequency of missed well-baby check-ups.²⁵ Postpartum depression may also lead to adverse outcomes for the infant, including impaired child development, including poor cognitive functioning, emotional maladjustment, and behavioral inhibition.^{26, 27}

Anxiety disorders during pregnancy have been associated with preterm birth, low birth weight, pre-eclampsia, and miscarriage,²⁸⁻³⁴ deficits in bonding, less attunement to infant cues,³⁵ and have an overall unfavorable impact on infant and child development.³⁶ Episodes of bipolar disorder during pregnancy and the postpartum period are associated with greater risk of low birth weight, preterm delivery, cesarean section, and diminished prenatal care; following delivery, there is increased risk of impaired bonding and attentiveness to infant cues.³⁷ Finally, OCD

1.1 Introduction, Background

during pregnancy is associated with greater risk of preterm birth and low birthweight³⁸ and has been shown to have a deleterious impact on infant bonding and attachment.³⁹

Given the known deleterious impact of untreated and undertreated perinatal depression, anxiety, PTSD, bipolar disorder, and OCD, early intervention in the perinatal period is paramount.⁴⁰ Appropriate pharmacologic treatments for perinatal mental health conditions are an important component of treatment, despite insufficient direct evidence for this population.⁴¹ For example, in partnership with the American College of Obstetrics and Gynecology (ACOG) and American Psychiatric Association (APiA), the Agency for Healthcare Research and Quality published a systematic review (SR) of pharmacologic treatment for mental health conditions in preconception, antepartum, postpartum, and lactating individuals.⁴¹ The review found few studies conducted in pregnant and postpartum individuals on the benefits of pharmacotherapy; many studies reported on harms but were of low quality. As in the general population, nonpharmacologic treatments for mental health conditions are often preferred over medications,⁴² a preference that is amplified for perinatal individuals given pregnancy and breastfeeding concerns.^{43, 44} Even when pharmacologic treatment is used, nonpharmacologic treatments may be important adjunctive therapies.

Numerous nonpharmacologic interventions have been considered for perinatal mental health. Common nonpharmacologic psychotherapy treatments for perinatal mental health conditions of interest include cognitive behavioral therapy (CBT)⁴⁵ and interpersonal psychotherapy.⁴⁶ For mild to moderate depression in the general population, complementary therapies, such as exercise, yoga, bright light therapy, and acupuncture have also shown efficacy and are often utilized.^{47, 48} Previous research has indicated that a poor marital or primary relationship is associated with perinatal depression¹ therefore, couples or family therapy can be effective as a primary or adjunctive treatment.⁴⁹ The delivery of counseling treatments via support groups,⁵⁰ home visiting,⁵⁰ and specialized psychiatric partial hospital programs⁵¹ have also been investigated. Common treatments for generalized anxiety disorders in the general population include CBT, mindfulness, yoga, exercise, and meditation.^{52, 53} In the general population, nonpharmacologic interventions for PTSD can include exposure therapy, trauma-focused CBT, eye movement desensitization and reprocessing therapy, interpersonal psychotherapy, explorative therapy, and self-hypnosis and relaxation.⁵⁴ While pharmacologic interventions are important for the treatment of bipolar disorders, adjunctive nonpharmacologic treatments are important interventions; for example, interpersonal and social rhythm therapy is an effective stand-alone or adjunctive therapy that may be effective in the perinatal population.⁵⁵ Other documented effective adjunctive treatments for bipolar disorder include psychoeducation,⁵⁶ mindfulness,⁵⁷ and cognitive remediation therapy.⁵⁸ Finally, nonpharmacologic interventions for OCD may include CBT combined with exposure response prevention, which has shown to be effective in the general population.⁵⁹

Clinical practice guidelines (CPGs) and consensus statements for the general population and perinatal individuals have tended to routinely recommend the use of nonpharmacologic interventions as either frontline interventions or as an adjunctive therapy with pharmacologic interventions.⁶⁰⁻⁶³ However, the CPGs do not include the latest evidence, are largely outdated, and/or focus on specific therapies. While some SRs exist on nonpharmacologic interventions for perinatal mental health, most focus on single types of interventions and have varying search dates and levels of rigor. Such diversity is challenging for CPG developers to consolidate to inform a single guideline. Thus, decision makers face the following decisional dilemmas: (1) whether to offer nonpharmacologic interventions alone or in combination with pharmacologic

1.1 Introduction, Background

interventions for specific perinatal mental health conditions, and (2) which nonpharmacologic interventions (and their possible combinations) for perinatal mental health provide the optimal patient outcomes.

1.2 Purpose of This Review

The purpose of this SR is to assess the comparative effectiveness and harms of nonpharmacologic treatments for mental health conditions (i.e., depression, anxiety disorder, bipolar disorder, OCD, and PTSD) among perinatal individuals. The SR evaluates the comparative effectiveness of nonpharmacologic treatments compared with each other (Key Question 1) and the effectiveness of nonpharmacologic treatments compared with pharmacologic treatments or combined nonpharmacologic and pharmacologic treatments compared to nonpharmacologic treatments alone (Key Question 2). This SR will potentially inform future guidance developed by ACOG, APiA, and American Psychological Association (APoA) for treatment of mental health conditions during the perinatal period. The topic of this SR was nominated by ACOG in partnership with the APiA.

2. Methods

2.1 Review Approach

The Evidence-based Practice Center followed established methodologies as outlined in the Agency for Healthcare Research and Quality (AHRQ) Methods Guide for Effectiveness and Comparative Effectiveness review.⁶⁴ The protocol for this review was registered in advance on PROSPERO (Registration number: CRD42023440650).

The topic of this review and preliminary Key Questions (KQs) arose through a process of soliciting input from the nominators (the American College of Gynecologists [ACOG]) and the American Psychiatric Association [APiA]), the American Psychological Association (APoA), a panel of Key Informants (KIs), a Technical Expert Panel (TEP), the public, and AHRQ. The KIs and TEP represented ACOG, researching and practicing obstetricians/gynecologists, clinical psychologists, social workers, doulas, women's health organizations, and patients. The KIs and TEP gave input on the KQs, definition of the perinatal period, and list of prioritized outcomes.

Additional information related to the methods and results can be found in the appendixes. Appendix A presents additional information about the methods including the full search strategy, cutoffs for defining mental health conditions and the intervention coding taxonomy. Appendix B presents the excluded studies with reasons for exclusion. Appendix C summarizes studies included in the evidence map for KQ 1 (Table C-1) and KQ 2 (Table C-2), and the characteristics of the studies included for full extraction and synthesis (Tables C-3 and C-4). Appendix D outlines the outcomes extracted for each study by mental health condition. Appendix E presents the risk of bias assessment for all extracted studies. Appendix F presents additional results tables.

2.2 Key Questions

Key Question 1: What are the effectiveness and comparative effectiveness and harms of nonpharmacologic treatments for mental health conditions in perinatal individuals?

- a. Depressive disorders
- b. Anxiety disorders
- c. Bipolar disorder
- d. Post-traumatic stress disorder
- e. Obsessive-compulsive disorder

Key Question 2: What are the comparative effectiveness and harms of nonpharmacologic treatments compared with pharmacologic treatment alone for mental health conditions in perinatal individuals?

2.2 Methods, Key Questions

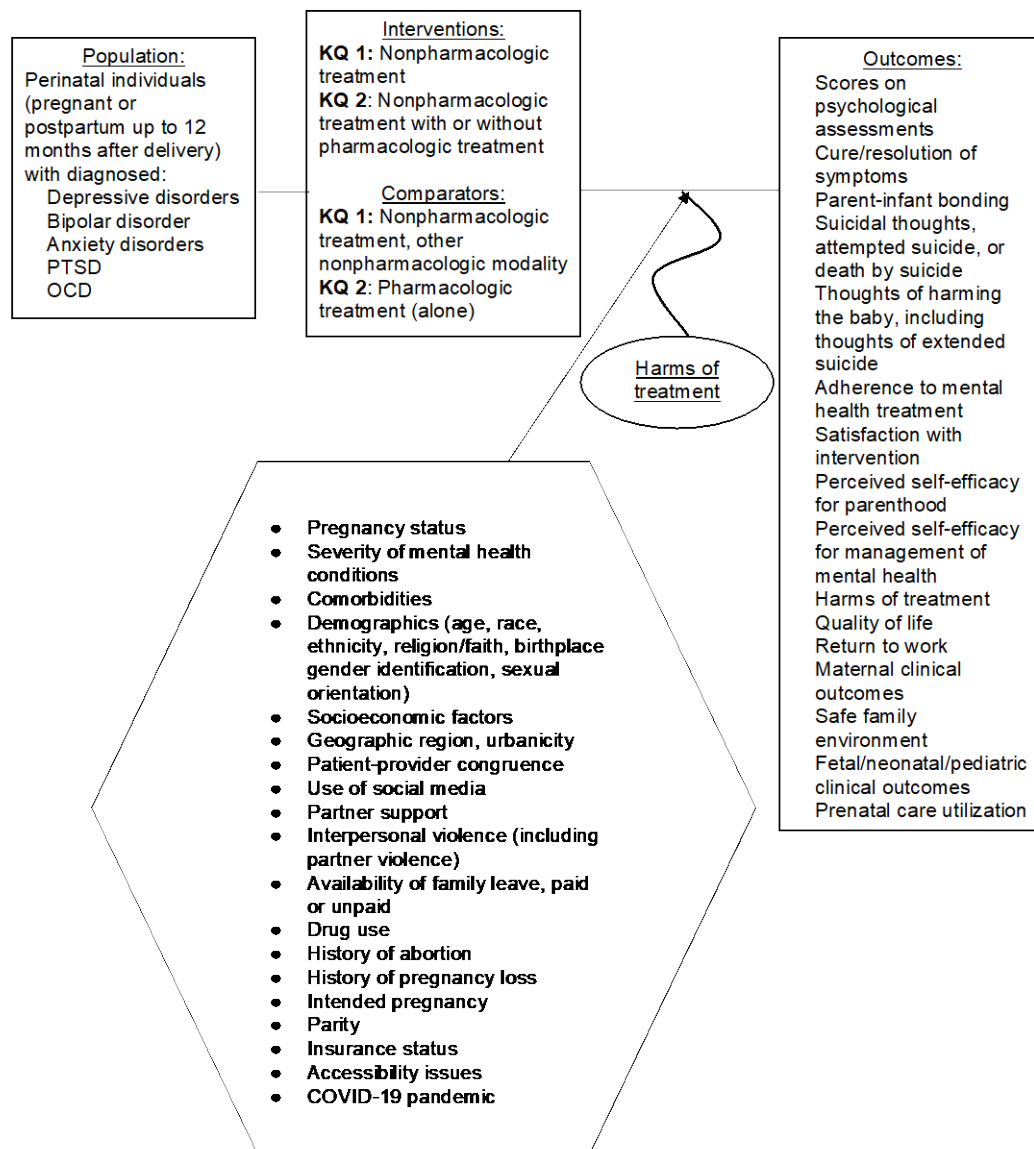
- a. Depressive disorders
- b. Anxiety disorders
- c. Bipolar disorder
- d. Post-traumatic stress disorder
- e. Obsessive-compulsive disorder

2.3 Analytic Framework

Based on discussions with KIs and the TEP members, we developed an analytic framework for the two KQs (Figure 1).

2.3 Methods, Analytic Framework

Figure 1. Analytic framework for Key Questions 1 and 2: Nonpharmacologic interventions for mental health conditions in perinatal individuals



Abbreviations: KQ = Key Question, OCD = obsessive-compulsive disorder, PTSD = post-traumatic stress disorder, COVID-19= coronavirus 2019

2.4 Literature Search

Literature searches were conducted on January 17, 2024, in Medline[®] (via PubMed[®]), PsycINFO[®], Embase[®], CINAHL[®], the Cochrane Register of Clinical Trials, and the Cochrane Database of Systematic Reviews. We also ran a search in ClinicalTrials.gov to capture references to published studies the literature searches may have missed. We did not employ language restrictions. We included filters to remove nonhuman studies and to restrict to randomized

2.5 Methods, Study Eligibility

controlled trials (RCTs) or systematic reviews. The search strategies were peer reviewed by another Evidence-based Practice Center librarian. Appendix A, Section A.1, presents all search strategies in full.

Reference lists from existing systematic reviews were searched to identify additional articles that met the inclusion criteria.

2.5 Study Eligibility

Table 1 and the paragraphs below outline the eligibility criteria for KQs 1 and 2. In brief, we included (only) RCTs of pregnant or postpartum (up to 1 year) individuals with diagnosed mental health conditions (depressive disorder, anxiety disorders, bipolar disorder, obsessive-compulsive disorder [OCD], or post-traumatic stress disorder [PTSD]) that compared a nonpharmacologic treatment with either an inactive comparator, another nonpharmacologic treatment, or a pharmacologic treatment. Study participants had to be in an ambulatory setting (i.e., not hospitalized, except related to their pregnancy, or institutionalized) in a high-income country. Studies were limited to RCTs as they provide the strongest evidence when assessing the comparative effectiveness of treatments. Due to the large body of evidence and resource constraints we limited this review to studies conducted in high income countries. We expect these studies will have the greatest applicability to U.S. settings. We excluded studies published before 2000 to be most applicable to contemporary practice.

Table 1. Inclusion and exclusion criteria

Eligibility Categories	Inclusion Criteria	Exclusion Criteria
Population	<ul style="list-style-type: none">• Perinatal individuals (pregnant or up to 12 months postpartum)• With new or preexisting diagnosis of depression disorder, bipolar disorder, anxiety disorders, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD)• Diagnoses must be confirmed via clinical interview or validated screening tool with a commonly accepted threshold	<ul style="list-style-type: none">• Studies that evaluate patients with depressive or anxiety symptoms in contrast with diagnoses of depression or anxiety, including studies that include patients with screening tool values below a threshold consistent with diagnosis• Populations in which the primary condition is phobia of pregnancy (i.e., tokophobia)• Studies with mixed populations (e.g., perinatal and non-perinatal, mental health condition and non-mental health condition), unless >90% of the studied population represent an eligible population for the review. This exclusion criterion does not apply to populations with multiple eligible mental health conditions; studies of perinatal individuals with two or more conditions (e.g., studies targeting individuals with both depression and anxiety) will be included.• Studies of patients with substance use disorders, exclusively.

2.5 Methods, Study Eligibility

Eligibility Categories	Inclusion Criteria	Exclusion Criteria
Intervention/Comparator	<p><u>Key Question 1:</u> Nonpharmacologic treatment versus other nonpharmacologic modality. May include same pharmacologic co-intervention as intervention group.</p> <p><u>Key Question 2:</u> Intervention must be nonpharmacologic intervention alone (no use of pharmacologic therapy). Comparators must be pharmacologic treatment alone</p>	<ul style="list-style-type: none"> Studies with interventions that are poorly specified or not structured programs (i.e., cannot be reasonably replicated in practice or future research) Unsupervised peer-to-peer or social media interventions Interventions delivered through ingestion or parenterally, and surgical or invasive interventions (with the exception of acupuncture) (e.g., omega-3 fatty acid, St. John's wort, kava, valerian, theanine) Interventions designed to address issues other than the mental health conditions of interest (e.g., diet changes, weight loss, lactation training, reintroduction of sexual activity) Interventions focused on the processes of delivering of care (e.g., collaborative care model)
Setting	<ul style="list-style-type: none"> Ambulatory with exception of individuals in hospital due to non-mental health pregnancy or postpartum complications Any treatment delivery method (including in-person, telehealth, digital) High-income countries (as defined by World Bank as of May 11, 2023) 	<ul style="list-style-type: none"> Exclude patients in acute inpatient psychiatric or other institutional settings Studies set in middle- and low-income countries
Design	<ul style="list-style-type: none"> Randomized controlled trials 	<p>Nonrandomized comparative studies Single group (noncomparative) studies, including case reports or series Studies with N<10 per arm Studies published only in dissertation or conference abstract format Studies published before 2000</p>

2.5.1 Population

We included studies of perinatal individuals who were either pregnant or postpartum (up to 12 months post-delivery). To be included, participants had to have a new or preexisting mental health diagnosis. Diagnoses could include depressive disorder, anxiety disorders, bipolar disorder, PTSD, or OCD. Anxiety or depression diagnoses had to be confirmed via a structured clinical interview, diagnostic tool, or by using a validated screening tool with a commonly accepted cutoff. However, for less commonly investigated perinatal disorders (e.g., PTSD and OCD) we did not require screening tools to meet previously defined cutoffs. See Appendix A, Section A.2, for a full list of screening tools and cutoffs employed by this review.

2.5.2 Intervention/Comparator

Studies had to evaluate one or more nonpharmacologic modalities. Nonpharmacologic treatments included (but were not limited to) acupuncture, behavioral activation, bright light therapy, cognitive behavioral therapy (CBT), counseling, exercise, eye movement desensitization

2.5.2 Methods, Study Eligibility, Intervention/Comparator

and reprocessing therapy (EMDR), and interpersonal therapy (IPT). Any nonpharmacologic intervention with the primary aim of treating perinatal mental health conditions was considered for inclusion. We excluded poorly specified interventions, unsupervised peer-to-peer or social media, ingestible treatments, and process of care interventions. Studies comparing two nonpharmacologic treatments to each other were included for KQ 1. Studies comparing pharmacologic or nonpharmacologic combined with pharmacologic to nonpharmacologic treatments were included for KQ 2.

2.5.3 Outcomes

We excluded studies that did not report outcomes of interest (whether prioritized or not). Prioritized outcomes are evaluated for strength of evidence (SoE). Prioritized outcomes for this review were a combination of outcomes listed in the Core Outcome Measures in Effectiveness Trials (COMET) initiative's core outcome set for perinatal depressive disorders⁶⁵ and outcomes identified in discussion with the KIs and TEP. Nonprioritized outcomes are summarized, but without SoE assessment.

Prioritized outcomes included:

- Psychological assessment tool scores (including self-assessed symptoms of mental health condition)
- Cure/resolution of symptoms or condition
- Parent-infant bonding
- Suicide (including suicidal thoughts, attempted suicide, or death by suicide)
- Adherence to treatment

Nonprioritized outcomes included:

- Satisfaction with intervention
- Perceived self-efficacy for parenthood
- Perceived self-efficacy for management of mental health
- Harms of treatment
- Quality of life
- Return to work
- Maternal clinical outcomes (e.g., preeclampsia, preterm delivery)
- Safe family environment
- Fetal/neonatal/pediatric clinical outcomes (e.g., live birth, infant feeding success, infant growth, pediatric death, pediatric development [e.g., neurodevelopmental milestones], pediatric cognitive and academic achievement, pediatric social/emotional wellbeing)
- Prenatal care utilization (e.g., completion of prenatal visits, completion of recommended prenatal services, unexpected healthcare utilization [e.g., emergency department/triage visits], postpartum care followup)

Potential modifiers included:

- Pregnancy status (pregnant, postpartum after live birth, postpartum after fetal loss or infant death or needing intensive care, breastfeeding; change of status within study period)

2.5.3 Methods, Study Eligibility, Outcomes

- Severity of mental health conditions (e.g., mild, moderate or severe depression; depression with or without anxiety, psychosis)
- Comorbidities, including other mental health conditions
- Age
- Race/ethnicity
- Religion/faith
- Birthplace (e.g., immigrant from Latin America versus. U.S.-born)
- Gender identification
- Sexual orientation
- Socioeconomic factors
- Geographic region, urbanicity
- Patient-provider congruence (e.g., with respect to racial, ethnic, language, and other socioeconomic factors)
- Use of social media
- Partner support
- Interpersonal violence (including partner violence)
- Availability of family leave, paid or unpaid
- Drug use
- History of abortion
- History of pregnancy loss
- Intended pregnancy
- Parity
- Insurance status
- Accessibility issues (e.g., internet access, in particular for telehealth interventions)
- COVID-19 pandemic (as defined by study authors)

2.6 Screening Studies for Eligibility

Citations from all searches were deduplicated and then entered into Abstrackr software (<http://abstrackr.cebm.brown.edu/>) to enable title and abstract screening. The team conducted several rounds of pilot screening. During each pilot round, the team all screened the same 100 abstracts and discussed conflicts, with the goal of training the team in the nuances of the eligibility criteria and refining the criteria as needed. After the pilot rounds, we continued abstract screening in duplicate. The Abstrackr software has machine learning capabilities that predict the likelihood of relevance of each citation. Daily, the list of unscreened abstracts was sorted so that the most potentially relevant articles were presented first. This process made the screening more efficient and enabled us to capture almost all relevant articles relatively early in the abstract-screening process. Consistent with the approach we have used for all our reviews in the past 5 years, we used standardized methods to leverage Abstrackr's machine learning capacities to constrain the number of citations that needed human screening.

We trained the machine learning algorithm using the following method: (1) We included references of known existing potentially relevant studies for each KQ. (2) We selected the top 100 articles from our search using each database's Best Match ("most relevant") algorithm. These were combined with 86 known relevant studies not captured by the best match algorithms. This strategy is based on a study by Sampson et. al⁶⁶ which showed that, for PubMed, the Best

2.6 Methods, Screening Studies for Eligibility

Match algorithm could create small training sets that included a higher concentration of relevant studies. (3) To expedite the training of the algorithms, the abstracts from steps 1) and 2) were entered into Abstrackr and screened by all team members, with resolution of all conflicts in conference. (4) Subsequently, the remaining citations found by the full literature searches were added to the already-screened citations in Abstrackr, and abstract screening continued in duplicate. (5) Machine learning continued throughout the screening process, with new potential-relevance (prediction) values applied to each unscreened citation nightly.

At all screening stages, conflicts were adjudicated in conference or by a third screener. Screening continued, in duplicate, until stopping criteria were reached. The stopping criteria employed are based on empirical evidence from dozens of screening projects conducted over the past 10 years and simulation analyses (manuscript pending). We stopped screening when the maximum prediction of remaining unscreened citations was <0.40 (on a scale of 0 to 1) and a subsequently screened 400 citations are rejected in a row.

We are very confident that our described approach is highly effective, with very low risk of eligible studies missed because they were “rejected” by Abstrackr (and were, thus, unscreened by team members). Our confidence is based first on the empirical and simulation evidence of the effectiveness (high sensitivity) of the described approach. In addition, using this approach, we have not had an instance where missed studies made known to us had been rejected by Abstrackr. Of note, approximately 25 percent of the Best Match and known studies were accepted at the citation screening level, but approximately 75 percent of the citations retrieved for full-text screening were found among the remaining citations found by the full literature searches.

Potentially relevant citations were retrieved in full text and rescreened in duplicate. At all stages, and conflicts were resolved in team conference or by the review Lead.

2.7 Data Extraction and Management

2.7.1 Classification of Studies for Full Data Synthesis or Appendix Evidence Map

In consultation with the TEP and sponsors, given the large body of evidence and numerous interventions and comparisons for nonpharmacologic treatments of depression and anxiety, and given time and resource constraints, we made the a priori decision to restrict full data synthesis for these conditions to comparisons with three or more studies. Our logic is that the more commonly reported comparisons are those that researchers have deemed to be of greatest interest and are the comparisons we are most likely to be able to make conclusions about (beyond “insufficient evidence”). To avoid missing other comparisons with adequate (not insufficient) evidence, we also extracted data from comparisons with at least one large ($N \geq 100$ per group) that was of low or moderate risk of bias. In addition, for instances where three or more studies evaluated a given comparison of interventions, we analyzed all prioritized outcomes, even if fewer than three studies reported the outcome. We did not impose this restriction for smaller evidence bases (i.e., comparisons of interventions for the treatment of anxiety disorder, PTSD, bipolar disorder, or OCD).

Otherwise-eligible (small) studies evaluating rare comparisons for depressive or anxiety disorders are summarized in an evidence map in Appendix C. For studies included in the appendix map, data extraction was limited to perinatal mental health disorder, perinatal period,

2.7.1 Methods, Data Extraction and Management, Classification of Studies for Full Data Synthesis or Appendix Evidence Map

interventions, study inclusion criteria, sample size per study arm, and primary findings. A risk of bias assessment was not conducted for these studies and we did not evaluate SoE.

2.7.2 Extraction and Management for Studies Meeting Criteria for Full Data Synthesis

For studies meeting criteria for full data synthesis, we extracted data and conducted risk of bias assessments directly into Systematic Review Data Repository Plus (SRDR+) software (<https://srdplus.ahrq.gov>). Data were entered by one highly experienced researcher and reviewed by at least one other. For each study, we extracted publication identifying data, study design features (including definitions used to define the eligible population), population characteristics, intervention and comparator names and descriptions (including intervention content, duration, modes of delivery, personnel delivering the intervention and setting in which it is delivered), relevant outcomes and their definitions, results, and funding source. We extracted, as available, data on the effect modifiers that are relevant to the KQs being addressed by each study.

We also entered studies included only in the evidence map into SRDR+, but limited data extraction to intervention names, sample sizes, and a text summary of the main findings.

2.8 Intervention Coding

Intervention and comparison details were extracted prior to full data extraction to determine which studies would be included in the appendix and which studies would be included in the full synthesis. We adapted and applied an intervention taxonomy from our recent review of complex interventions for substance use disorders to code the interventions.^{67, 68} All studies were coded by an expert in nonpharmacologic interventions. The intervention coding was regularly reviewed with the clinical experts on our team to ensure the coding taxonomy was appropriately applied.

The following principles guided intervention coding:

- a. Due to inconsistency in the terminology used to define specific nonpharmacologic treatments across studies, codes were applied based on how the intervention was described in the study, rather than the name of the study arm.
- b. Intervention components had to be unique and distinct from one another (e.g., if a study described an educational component in the context of adapting an existing manualized treatment to the perinatal population, we did not code education unless there was a distinct psychoeducational session or module).
- c. As it is expected that participants would be receiving routine pre- and post-natal care, all forms of control groups (e.g., informational leaflets, waitlist control, treatment as usual, enhanced usual care) were categorized as treatment as usual.

Appendix A, Section A.3, presents the coding taxonomy in full. Coding rules for each intervention category (listed alphabetically) are described in the following subsections.

2.8.1 Acupuncture

Interventions were coded as acupuncture if there was a description of insertion and stimulation of needles in prespecified areas of the body. Elements of massage therapy may also

2.8.1 Methods, Intervention Coding, Acupuncture

be included in an acupuncture intervention. Control interventions are typically variations of sham acupuncture (where needles are not fully inserted or stimulated).

2.8.2 Behavioral Activation

Behavioral activation (BA) is a common technique utilized by CBT interventions that targets the relationship between behaviors and feelings. While BA is most commonly used alongside other cognitive and behavioral techniques, it can also be used as a treatment on its own. Interventions were coded as BA if they aimed to change participants emotions by encouraging them to change their behaviors without reference to other CBT techniques or skills.

2.8.3 Bright Light Therapy

Bright light therapy (BLT) aims to reduce symptoms of depression by increasing the participants daily exposure to bright light that mimics natural outdoor light. Interventions were coded as bright light therapy if it was described as including exposure to bright light (typically at a predetermined luminosity or color temperature) using a light box or similar device. Comparisons to BLT include exposure to light at a lower luminosity or color temperatures that do not mimic outdoor light. All such comparisons in this review were coded as placebo light therapy.

2.8.4 Cognitive Behavioral Therapy

CBT is a psychotherapy based on the principle that psychological problems are based, in part, on unhelpful ways of thinking or behavior and can be addressed by leaning better ways of coping with them. We coded an intervention as containing CBT if the intervention was described as aiming to change the participants thoughts or behaviors utilizing cognitive and behavioral strategies. Interventions with additional components to enhance engagement (e.g. a motivational interviewing engagement session) or area of focus (e.g. trauma-focused CBT) were coded as CBT.

2.8.5 Exercise

An intervention was coded as including exercise if it was described as increasing movement with one specified component of either duration, intensity or frequency.

2.8.6 Eye Movement Desensitization and Reprocessing Therapy

EMDR (Eye Movement Desensitization and Reprocessing Therapy) is a psychotherapy aimed at accessing and reprocessing participant's traumatic memories. It is based on the Adaptive Information Processing model, which proposes that symptoms of PTSD and other mental health disorders result from the inadequate processing of memories of disturbing events. Interventions were coded as EMDR if they referenced targeting memories and incorporated the use of eye movements or other forms of bilateral stimulation.

2.8.7 Interpersonal Therapy

IPT is a brief attachment and communication focused therapy that aims to reduce symptoms of depression or anxiety through improving the participant's interpersonal relationships and

2.8.7 Methods, Intervention Coding, Interpersonal Therapy

enhancing social support. Interventions described as addressing the participant's interpersonal relationships were coded as IPT, as were interventions based on IPT principles (e.g. interpersonal counseling).

2.8.8 Non-Directive Counseling

Non-directive counseling (also known as client-centered therapy, person-centered therapy or listening visits) aims to help recipients understand their own feelings, actions and values. Non-directive counseling sessions are led by the participant and the role of the therapist is to provide empathy and unconditional positive regard through active and reflexive listening. Interventions were coded as non-directive counseling if they were described as participant led, involved empathetic or reflexive listening or were described as listening visits.

2.8.9 Psychoeducational Interventions

Psychoeducational interventions are interventions explicitly designed to reduce symptoms of the participant's symptoms through the provision of educational materials. Psychoeducational interventions may also be described as education(al), psychosocial education(al), or educational. Most nonpharmacologic interventions include some degree of educational content, particularly where pre-existing manualized interventions (e.g., CBT) are adapted for the perinatal population. Interventions were coded psychoeducational if there was explicit reference to a stand-alone psychoeducational module or intervention. Educational components that were described in the context of adapting existing nonpharmacologic interventions for the perinatal population were not coded as psychoeducation.

2.8.10 Yoga

An intervention was coded as yoga if it consisted of gentle stretching or holding postures (asana), exercises for breathing control (pranayama), and drawing a connection between the mind and body through meditation exercises.

2.8.11 Treatment as Usual

Interventions designed to be comparators to active intervention and were not directed at treating perinatal mental health disorders were categorized as treatment as usual (TAU). Common comparison groups in RCTs testing nonpharmacologic treatments for perinatal mental health disorders include: waitlist control, educational materials, and simply "treatment as usual". TAU varies depending on the context in which the study was conducted and may include, but was not limited to, monitoring by the participant's primary care provider or obstetrician, home-visits from social workers, midwives or doulas, or community mental health services.

2.8.12 Delivery Characteristics

We extracted details on the contents of the interventions and how they were delivered. We extracted information related to the number of, duration, and frequency of intervention sessions, the mode of delivery, setting and who delivered the intervention. Where sufficient data were available, we used information related to the mode of delivery and setting for sub-group analyses.

2.9 Assessment of Risk of Bias in Individual Studies

For studies meeting criteria for full data synthesis, we evaluated each study for risk of bias and methodological quality using the Cochrane Risk of Bias Tool⁶⁹ which addresses issues related to randomization and allocation concealment methodology; blinding of patients, study personnel/care providers, and outcome assessors; incomplete outcome data; selective outcome reporting; and other issues that could be related to bias. We also added questions about reporting clarity to ensure that the population, interventions, outcomes, and results were clear and consistent.

We provided an overall rating of the risk of bias for each study. Studies were rated as low if they were determined to be low risk of bias in all domains. Studies were rated as moderate risk of bias if there was either high risk of bias for one domain but low risk of bias for all others, or high risk of bias for one domain and unclear risk of bias for two or more domains. Studies were rated as high risk of bias if they were rated as high risk of bias in two or more domains. Studies that were rated as unclear risk of bias in multiple domains were rated as unclear risk of bias overall.

2.10 Data Synthesis

We conducted standard pair-wise meta-analyses for prioritized and nonprioritized outcomes, where we included at least three sufficiently similar trials reporting on the same population (by mental health condition), treatment comparison, and sufficiently similar outcome. We used restricted maximum likelihood random-effects model meta-analyses. For meta-analysis of continuous data, where we identified a wide variety of measures that assessed the same domain (e.g., depressive symptoms) we calculated and meta-analyzed between-group standardized mean differences (SMDs) using Hedges' *g*, which corrects for bias arising from small samples. Where studies reported multiple measures assessing the same domain, we selected the most frequently reported measure(s) across studies included in the meta-analysis. For binary outcomes, we calculated relative risk (RR). Studies reporting relevant outcomes were excluded from meta-analyses if they did not report sufficient data to reliably estimate SMDs or RRs.

Where possible we conducted subgroup analyses exploring whether effect sizes differed depending on the diagnostic tool used to assess participants at study enrollment (i.e. structured diagnostic tool versus screening tool), the mode of intervention delivery (e.g. individual, group or self-guided) or the setting of the intervention (e.g. at the clinic, in the participant's home, or remote). We also sought subgroup analyses based on the modifiers listed in Section 2.5.3.

All prioritized outcomes were synthesized, regardless of whether meta-analysis was feasible.

2.11 Grading the Strength of Evidence for Major Comparisons and Outcomes

We graded SoE per the AHRQ Methods Guide.⁷⁰ We assessed SoE for each of the prioritized outcomes. For each SoE assessment, we considered the number of studies, their study designs, the study limitations (i.e., risk of bias and overall methodological quality), the directness of the evidence to the KQs, the consistency of study results, the precision of any estimates of effect, the likelihood of reporting bias, other limitations, and the overall findings across studies. Based on

2.11 Methods, Grading the Strength of evidence for Major Comparisons and Outcomes

these assessments, we assigned a SoE rating as being either high, moderate, low, or insufficient evidence to estimate an effect.

Outcomes with imprecise estimates or inconsistent findings across studies that preclude a conclusion or (in most instances) with data from only one study were deemed to have insufficient evidence to allow for a conclusion. The exception was that a large ($N > 100$ per group), low risk of bias, well-generalizable single study could provide at least low SoE. Non-significant estimates with a 95% confidence interval that extends beyond 0.2 SMD were considered imprecise and without sufficient evidence to determine equivalence. This approach is consistent with the concept that for imprecise evidence “any estimate of effect is very uncertain,” the definition of Very Low-quality evidence per Grading of Recommendations Assessment, Development and Evaluation (GRADE).⁷¹

In accordance with AHRQ guidance for describing treatment effects,^{72, 73} we have incorporated qualifying language regarding SoE when communicating conclusions (e.g., in Key Points sections of the text) as follows: “probably” for conclusion statements with moderate SoE and “may” for conclusion statements with low SoE. Conclusions with high SoE do not include qualifiers.

2.12 Assessing Applicability

For each KQ, we assessed the applicability of the included studies to the general population of perinatal individuals with mental health conditions in the United States based primarily on the studies’ eligibility criteria and their included participants, specifically related to such factors as age, perinatal risk status, accessibility (financial or other resources required) of the intervention, and country.

To determine the clinical relevance of estimates derived from meta-analyses, we back transformed SMDs into points on a clinically relevant scale. We back-transformed SMDs of depressive symptoms to the Edinburgh Postnatal Depression Scale (EPDS) and SMDs of anxiety symptoms to the State Trait Anxiety Inventory (STAI).

2.13 Peer Review and Public Commentary

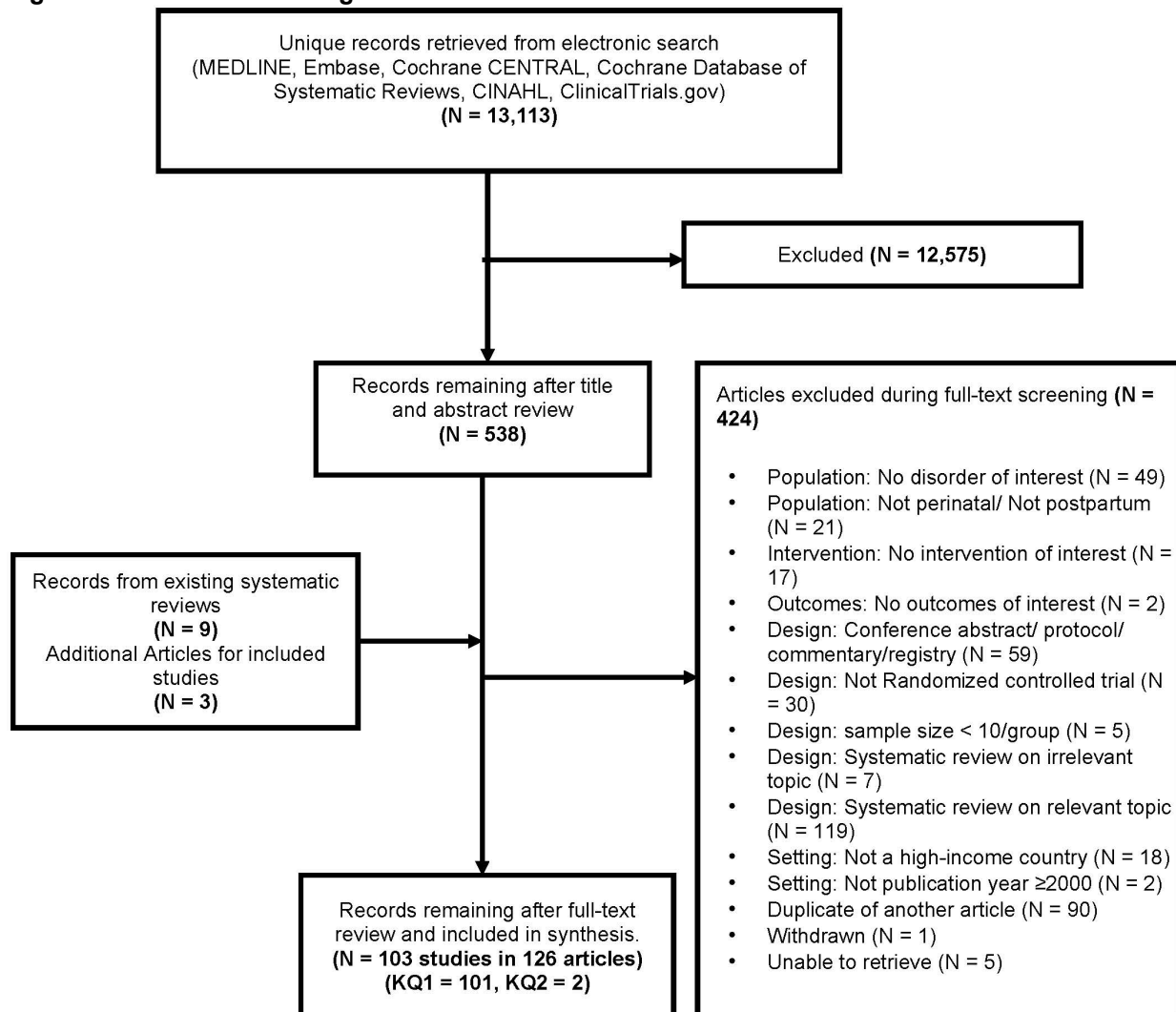
Experts in maternal mental health from a range of disciplines including psychology, psychiatry and obstetrics and gynecology, AHRQ, and individuals representing stakeholder and patient groups were invited to externally peer review this systematic review. This review was available for public comment (January 26, 2024, to February 26, 2024). The report was revised in light of reviewer comments. A disposition table of peer and public comments and responses will be posted about 3 months after publication of the final report on the AHRQ Effective Health Care website.

3. Results

3.1 Literature Search Results

The electronic literature search yielded 13,113 citations after deduplication. A total of 103 studies, reported in 126 articles, met inclusion criteria (Figure 2). Nine studies were identified by searching the references of existing systematic reviews and three articles reporting additional outcomes for already-included studies were identified by reviewing reference lists. Appendix Table B-1 provides a list of excluded studies.

Figure 2. Literature flow diagram



KQ = Key Question, CINAHL = Cumulative Index to Nursing and Allied Health Literature.

Of the 103 randomized controlled trials (RCTs) meeting the inclusion criteria, 101 RCTs addressed Key Question (KQ) 1, and 2 RCTs addressed KQ 2. Table 2 summarizes how many studies for KQs 1 and 2 met the criteria for full extraction and how many were summarized in an evidence map. For KQ 1, 71 RCTs met the criteria for full extraction and analysis⁷⁴⁻¹⁴³, and 30 RCTs evaluated infrequently-analyzed comparisons of interventions; the latter are summarized in

3.1 Results, Literature Search Results

an evidence summary in Appendix Table C-1.^{138, 144-174} Neither of the two studies identified for KQ 2 met the criteria for full extraction and analysis.^{175, 176} The two KQ 2 RCTs are briefly summarized in Section 3.4.2 and in Appendix Table C-2.

Table 2. Number of studies extracted fully and extracted to the evidence map by Key Question

Full Extraction or Evidence Map	KQ 1	KQ 2
Full Extraction	71	0
Evidence Map	30	2

Abbreviations: KQ = Key Question.

3.2 Description of Included Evidence

There were 71 RCTs that enrolled 8,889 participants included for full extraction and analysis for KQ 1. Details regarding the included studies designs and baseline characteristics are summarized in Appendix Tables C-2 and C-3. Most studies were conducted in the United States (N = 18), followed by the United Kingdom (N = 15), Canada (N = 13), Australia (N = 10), Sweden (N = 3), Hong Kong (N = 3), the Netherlands (N = 2), Denmark (N = 1), Germany (N = 1), Italy (N = 1), South Korea (N = 1), Switzerland (N = 1), Turkey (N = 1), and Japan (N = 1).

Among the 71 RCTs, 63 (88%) reported their source of funding. The majority of studies included in this review (N = 63, 88%) received non-industry funding. Only one study was funded by industry (Wiklund 2010). Eight studies did not report their source of funding. Conflict of interest status (COI) was reported in fifty studies. Most studies (57%) reported no conflicts of interest (N = 41) and nine studies declared authors' COI (such as royalties, attending educational events by pharmaceutical industries). COI status was not reported in 21 studies.

For the purpose of study eligibility criteria, perinatal mental health disorder was explicitly defined using diagnostic tool/criteria (with or without a validated scale or measure) by 44 studies. Most studies used diagnostic tools to identify participants with depression or anxiety (N = 42), however two studies used diagnostic tools to identify participants with post-traumatic stress disorder (PTSD). Thirty-three studies of depressive or anxiety disorders used Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria (either DSM-IV or DSM-IV-TR [Text Revised]). Six studies used International Classification of Diseases (ICD-10) criteria to define postnatal depression. One (German) study used the Munich-Composite International Diagnostic Interview to define depression and anxiety. For defining PTSD, one study used the Adult Attachment Interview (AAI) and one study used the Impact of Events Scale. The remaining 27 studies used only validated scales (not standardized diagnostic tools or criteria) to assess and measure depression, anxiety, or PTSD. The most frequent scale used to measure depressive symptoms was the Edinburgh Postnatal Depression Scale (EPDS), which was used in 20 studies. Four studies used the Beck Depression Inventory (BDI) and two used the Hamilton Depression Rating Scale (HAM-D). Two studies used the State Trait Anxiety Inventory (STAI) and three studies used the Generalized Anxiety Disorders Scale (GAD-7) to identify individuals with anxiety disorders.

Among the 71 RCTs, 27 (38%) enrolled pregnant people, 39 (55%) enrolled people in the year following birth, and 5 (7%) enrolled people at any stage of the perinatal period.

The majority of studies (77%, N = 55) included individuals with depressive disorder, of which 35 enrolled pregnant people and 15 enrolled people in the postpartum period. Two studies enrolled participants with anxiety disorders during the perinatal period. Five studies included people with PTSD (3 of which included prenatal PTSD). Six studies included participants with

3.2 Results, Description of Included Evidence

depression and/or anxiety disorders, and one study enrolled individuals in the postpartum period with obsessive-compulsive disorder (OCD).

The mean age of participants ranged from 17 to 35 years within studies, with a median age of 32.2 across studies. Most studies did not restrict eligibility based on participant age, but Madigan 2015 included only pregnant adolescents.¹⁰⁷

Race and/or ethnicity data were reported by 39 studies (55%). The median proportion of White participants across the included studies was 65.2 percent, Black participants was 26.0 percent, Asian participants was 4.0 percent, Hispanic participants was 16.5 percent, and 7.5 percent were from other racial and ethnic groups.

Marital status was reported by 57 studies (80%). The median proportion of married/currently partnered participants was 92.0 percent.

3.3 KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments

We identified 71 studies for full extraction and analysis related to KQ 1. The remaining 30 RCTs reported comparisons of interventions mostly in people with depression that were evaluated by fewer than three RCTs. These studies are summarized in Appendix Table C-1.

Most studies were two-arm RCTs (N = 65), however we also identified five three-arm RCTs and one four-arm RCT. See Appendix Table C-5 for a summary of all study arms.

Table 3 outlines the 71 fully evaluated studies assessing each interventions-comparison pair by mental health condition. Most studies (N = 56, 80%) tested the comparative effectiveness of nonpharmacologic treatments among perinatal individuals with depressive disorders alone. The next most common patient group was individuals with PTSD (N = 4, 6%), followed by individuals with combined depressive and anxiety disorders (N = 4, 6%), depressive or anxiety disorders (N = 3, 4%), anxiety disorders (N = 2, 3%), and OCD (N = 1, 1%). We did not identify any studies testing nonpharmacologic treatments for perinatal individuals with bipolar disorder. Appendix Tables D-1 to D-5 summarize the prioritized outcomes extracted by study.

The following sections assess the comparative effectiveness of nonpharmacologic conditions by mental health condition.

3.3 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments

Table 3. KQ 1: Number of studies that met criteria for full extraction by perinatal mental health disorder and intervention comparisons

Comparisons ^a	Depressive Disorders	Anxiety Disorder	Combined Depressive and Anxiety Disorders	Depressive or Anxiety Disorders	Bipolar Disorder	OCD	PTSD	Total ^{a,b}
BA versus TAU	3	0	0	0	0	0	0	3
Bright light therapy versus placebo light therapy	3	0	0	0	0	0	0	3
CBT versus Counseling	3	0	0	0	0	0	0	3
CBT versus TAU	28	1	3	3	0	1	3	39
Counseling versus TAU	3	0	0	0	0	0	1	4
EMDR versus TAU	0	0	0	0	0	0	0	1
Exercise versus TAU	6	0	0	0	0	0	0	6
IPT versus TAU	9	0	0	0	0	0	0	9
Specific versus non-specific acupuncture	3	0	0	0	0	0	0	3
Multicomponent intervention versus TAU	0	1	0	0	0	0	0	1
Yoga + Tai Chi versus TAU	0	0	1	0	0	0	0	1

^aMulti-arm RCTs were included in more than one intervention versus comparison categorization

^b32 RCTs had <3 RCTs per comparison and are summarized in Appendix Table C-1

Abbreviations: BA = behavioral activation, CBT = cognitive behavioral therapy, EMDR = eye movement desensitization and reprocessing, IPT = Interpersonal therapy, KQ = Key Question, OCD = obsessive-compulsive disorder, PTSD = post-traumatic stress disorder, RCT = randomized controlled trial, TAU = treatment as usual.

3.3.1 KQ 1: Key Points

- Findings from 71 RCTs of 8,889 individuals with perinatal mental health conditions were extracted and analyzed.
- For perinatal individuals with depressive disorders:
 - Cognitive behavioral therapy (CBT) was more effective than treatment as usual (TAU) to reduce depressive symptoms (moderate strength of evidence [SoE]) and anxiety symptoms (moderate SoE), and was associated with increased rates of remission for depressive symptoms (low SoE).
 - Interpersonal therapy (IPT) was more effective than TAU to reduce depressive symptoms (moderate SoE) and anxiety symptoms (low SoE), and was associated with increased rates of remission for depressive symptoms (low SoE).
 - Behavioral activation was more effective than TAU to reduce depressive symptoms (low SoE).

3.3.1 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Key Points

- Exercise interventions were more effective than TAU to reduce depressive symptoms (moderate SoE).
 - Specific acupuncture compared with nonspecific or sham acupuncture may be associated with increased remission rates for depressive symptoms (low SoE).
 - There insufficient evidence to determine equivalence in depressive symptoms at the end of treatment between CBT and non-directive counseling, non-directive counseling and TAU, and bright light and placebo light therapy.
- For perinatal individuals with anxiety disorders:
 - There was insufficient evidence to allow conclusions due to the heterogeneity of interventions.
- For perinatal individuals with combined depressive and anxiety disorders:
 - CBT was more effective than TAU to reduce depressive and anxiety symptoms (low SoE).
- For perinatal individuals with depressive or anxiety disorders:
 - There was insufficient evidence to determine equivalence between CBT and TAU.
- For perinatal individuals with PTSD:
 - There was insufficient evidence to allow conclusions due to the heterogeneity of study designs and outcomes.
- For perinatal individuals with OCD:
 - There was insufficient evidence to allow conclusion due to sparse evidence.
- For perinatal individuals with bipolar disorder:
 - We did not identify any studies evaluating the comparative effectiveness of nonpharmacologic treatments for bipolar disorder.
- There was insufficient evidence to draw conclusions regarding the potential harms of nonpharmacologic treatments for perinatal mental health conditions.

3.3.2 KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Fifty-three studies compared the effectiveness of nonpharmacologic treatments for individuals with depressive disorders. Table 4 summarizes the SoE of nonpharmacologic interventions for depressive disorders for prioritized outcomes.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Table 4. KQ 1: Strength of evidence of nonpharmacologic treatments for depressive disorders

Outcome Category	Outcome ^a	Comparison	N Studies (Participants)	RoB	Consistency	Precision	Directness	Overall SoE	Conclusions
Scores of psychological assessments	Depression	Acupuncture vs sham	3 (154)	Moderate	Inconsistent	Imprecise	Direct	Low	Acupuncture more effective
	Depression	BA vs TAU	3 (508)	Moderate	Consistent	Precise	Direct	Moderate	BA more effective
	Depression	BLT vs PLT	3 (100)	Moderate	Inconsistent	Imprecise	Direct	Low	Insufficient evidence
	Depression	CBT vs TAU	23 (2,414)	Moderate	Consistent	Precise	Direct	Moderate	CBT more effective
	Depression	CBT vs COUNS	3 (226)	Moderate	Consistent	Imprecise	Direct	Low	insufficient evidence
	Depression	COUNS vs TAU	2 (247)	Moderate	Consistent	Imprecise	Direct	Low	Insufficient evidence
	Depression	EXE vs TAU	5 (428)	Moderate	Consistent	Precise	Direct	Moderate	EXE more effective than TAU
	Depression	IPT vs TAU	9 (1,003)	Moderate	Consistent	Precise	Direct	Moderate	IPT more effective
	Anxiety	BA vs TAU	1 (59)	Unclear	N/A	Imprecise	Direct	Insufficient	No conclusions
	Anxiety	CBT vs TAU	8 (1,201)	Moderate	Consistent	Precise	Direct	Moderate	CBT more effective than TAU
	Anxiety	CBT vs COUNS	1 (103)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions
	Anxiety	COUNS vs TAU	1 (100)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions
	Anxiety	EXE vs TAU	1 (270)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions
	Anxiety	IPT vs TAU	3 (299)	Moderate	Inconsistent	Imprecise	Direct	Low	IPT more effective
Cure/ resolution of symptoms	Depression	Acupuncture vs sham	3 (139)	Moderate	Inconsistent	Imprecise	Direct	Low	Acupuncture more effective
	Depression	BA vs TAU	1 (56)	Unclear	N/A	Imprecise	Direct	Insufficient	No conclusions
	Depression	BLT vs PLT	2 (50)	Moderate	Inconsistent	Imprecise	Direct	Insufficient	No conclusions
	Depression	CBT vs TAU	4 (238)	Moderate	Consistent	Imprecise	Direct	Low	CBT more effective
	Depression	CBT vs COUNS	1 (50)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions
	Depression	COUNS vs TAU	1 (46)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions
	Depression	EXE vs TAU	1 (270)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions
	Depression	IPT vs TAU	4 (538)	Moderate	Inconsistent	Precise	Direct	Low	IPT more effective
Adherence	Adherence	BA vs TAU	1 (87)	Moderate	N/A	N/A	N/A	Insufficient	Only reported outcome BA group
	Adherence	EXE vs TAU	1 (88)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Outcome Category	Outcome ^a	Comparison	N Studies (Participants)	RoB	Consistency	Precision	Directness	Overall SoE	Conclusions
	Adherence	IPT vs TAU	2 (95)	Moderate	Inconsistent	Imprecise	Direct	Insufficient	No conclusions

^aComparisons with three or fewer studies in total are omitted

Abbreviations: BA = behavioral activation, BLT = bright light therapy, CBT = cognitive behavioral therapy, COUNS = counseling, EXE = exercise, IPT = interpersonal therapy, KQ = Key Question, N/A = not applicable, PLT = placebo light therapy, RoB = risk of bias, SoE = strength of evidence, TAU = treatment as usual.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.1 Specific Acupuncture Versus Non-Specific Acupuncture

Three studies compared specific acupuncture to nonspecific or sham acupuncture in 162 participants (Table 5). One study compared electroacupuncture needling of acupoints associated with depression compared with acupuncture with placebo needles. Two studies (Manber 2004 and Manber 2010) compared acupuncture treatments that needled acupoints researchers claimed were associated with depression to treatments that needled acupoints not associated with depression. In Manber 2004 and 2010 participants' acupuncture sessions were initially delivered twice weekly, which was later reduced to weekly. In the third RCT, Chung 2012, acupoints associated with depression were needled using electroacupuncture needles and the same points were needled in the nonspecific acupuncture using placebo needles. All interventions were delivered by certified acupuncturists. Two studies (Manber 2004 and Manber 2010) included participants in the prenatal period and Chung included participants in the postnatal period. Participants received a total of 8 sessions delivered twice weekly.

Table 5. Specific versus non-specific acupuncture for depressive disorders: Description of interventions and comparisons

Study, Year, PMID	Description of Specific Acupuncture	Description of Non-Specific Acupuncture	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Chung, 2012, 22840621 ¹⁷⁷	Electroacupuncture. Participants were needled at cranial and body acupoints. Delivered by certified acupuncturist.	Sham acupuncture: Subjects were treated at the same acupoints using placebo needles. Delivered by certified acupuncturist.	8	NR	Twice weekly	Postnatal
Manber, 2004, 15546651 ¹⁰⁸	Acupuncture treatments did not consist of a fixed set of points. Instead, treatments were individually tailored following the principles of traditional Chinese medicine. Delivered by certified acupuncturist.	Nonspecific acupuncture: Needle insertion in points not associated with depression. Delivered by certified acupuncturist.	Between 20 and 29	15-30 minutes	Twice weekly until delivery, weekly post-delivery	Prenatal
Manber, 2010, 20177281 ¹⁰⁹	Acupuncture specific for depression was tailored individually. Delivered by certified acupuncturist.	Nonspecific acupuncture: Acupuncture not specific for depression. Delivered by certified acupuncturist.	12	25 minutes	Twice weekly for 4 weeks then weekly for 4 weeks	Prenatal

Abbreviations: NR = not reported, PMID = PubMed identifier.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.1.1 Risk of Bias

The most common concerns were related to attrition bias (1/3 high and 1/3 unclear risk of bias) and selective reporting (2/3 unclear risk of bias). There was a low risk of bias related to blinding of outcome assessors. All other domains were rated low risk of bias.

3.3.2.1.2 Depressive Symptoms

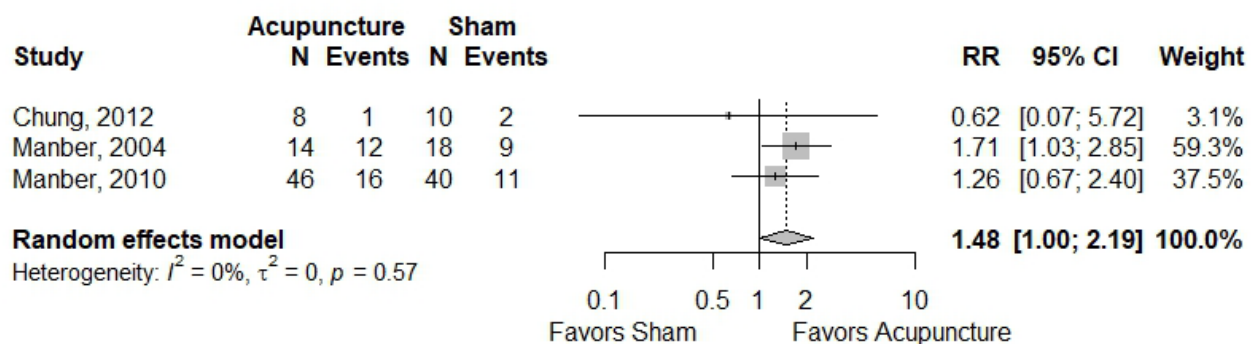
All three studies reported on depressive symptoms at the end of treatment using validated scales. One study (Manber 2010) reported on the mean difference between in depressive symptoms between baseline and end of treatment for each group. In Manber 2010 participants in the specific acupuncture group reported a mean reduction of 9.38 points (range not reported) and the nonspecific acupuncture group reported a mean reduction of 7.35 points (range not reported) between baseline and end of treatment on the HAM-D. Standardized mean differences (SMDs) were calculated for Chung 2012 and Manber 2004 using HAM-D scores. There was no difference in depressive symptoms at the end of treatment between the specific and nonspecific acupuncture groups (Chung 2012 SMD 0.40 95% confidence interval [CI] -0.54, 1.33; Manber 2014 SMD -0.38, 95% CI -1.06 to 0.29) (Appendix Table F-1).

3.3.2.1.3 Remission Rate of Depressive Symptoms

All three studies reported on the proportion of participants whose symptoms of depression reach remission at the end of treatment. All studies use the HAM-D to define remission; however, they used different cutoffs. Chung 2012 and Manber 2010 defined remission as a score of ≤ 7 , whereas Manber 2004 defined remission as a score of ≤ 8 .

Meta-analysis (Figure 3) provided evidence that depressive symptoms at the end of treatment remitted significantly in participants who received acupuncture compared to those who received sham acupuncture (summary relative risk [RR] 1.48, 95% CI 1.00 to 2.19, I^2 0%). The very small study by Chung 2012 was highly imprecise; thus, the summary estimate is primarily based on the two studies by Manber et al.

Figure 3. Specific versus nonspecific acupuncture for depressive disorders: Remission



Abbreviations: CI = confidence interval, RR = relative risk.

3.3.2.1.4 Response Rate of Depressive Symptoms

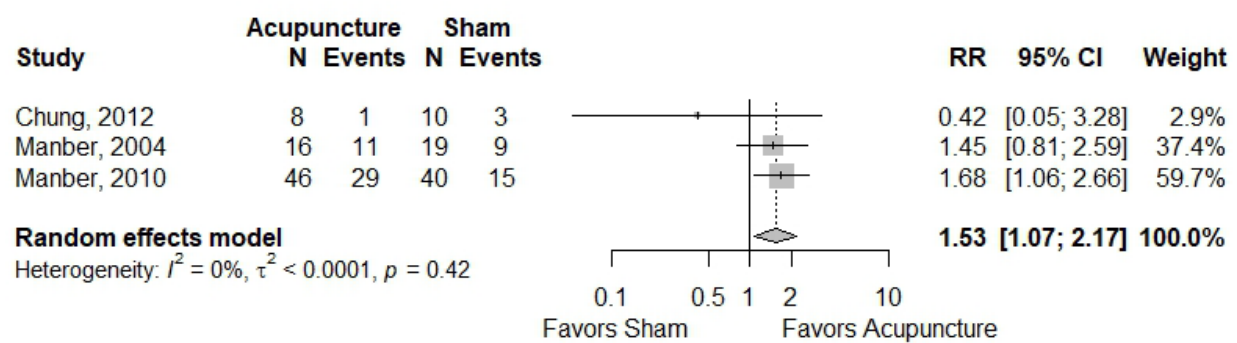
All three studies reported on response rates of depressive symptoms. Each study used a different definition of response. Chung 2012 defined response as a 50 percent or greater

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

reduction in scores on the HAM-D between baseline and end of treatment. Manber 2004 defined response as 50 percent or greater reduction in scores between baseline and end of treatment and a scores less than 14 on the HAM-D. Manber 2010 defined response as a 50 percent or greater reduction in scores on the HAM-D and a HAM-D score between seven and 14 at the end of treatment.

Meta-analysis (Figure 4) provided evidence that depressive symptoms at the end of treatment decreased significantly in participants who received specific acupuncture compared with those who received nonspecific acupuncture (summary RR 1.53, 95% CI 1.07 to 2.17, I² 0%). The very small study by Chung 2012 was highly imprecise; thus, the summary estimate is primarily based on the two studies by Manber et al.

Figure 4. Specific versus nonspecific acupuncture for depressive disorders: Response



Abbreviations: RR = relative risk ratio, 95% CI = 95% confidence intervals.

3.3.2.1.5 Harms of Treatment

One study (Manber 2010) reported on the proportion of participants who experienced any side effects after treatment (tiredness, irritability or agitation, sleep disturbance, headache, nausea, aggravation of depression). A greater proportion of participants in the specific acupuncture group experienced side effects compared with the nonspecific acupuncture group (26.5%) compared with sham acupuncture group (9.1%) (RR 2.92, 95% CI 1.03 to 8.29) study (Appendix Table F-2). Studies were inconsistent, with Chung indicating no difference between the groups and Manber 2004 and Manber 2010 favoring specific acupuncture.

3.3.2.1.6 Clinical Global Impression

One study (Chung 2012) assessed severity of illness, global and subjective improvements using the clinical global impression scale (CGI). There were no differences in severity of illness (SMD 0.67, 95% CI -0.29 to 1.62), global improvement (SMD 0.7, 95% CI -0.26 to 1.66), or subjective improvement (SMD 0.22, 95% CI -0.71 to 1.16) scores between the specific and nonspecific acupuncture groups (Appendix Table F-3).

3.3.2.2 Behavioral Activation Versus TAU

Three studies compared behavioral activation to TAU among 508 participants. Table 6 provides a description of the behavioral activation (BA) and TAU interventions. Two studies tested an online, self-guided intervention (O'Mahen 2014 and O'Mahen 2013). In each of the online self-guided intervention, participants were encouraged to complete online modules, but

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

had weekly access to chat rooms which were moderated by either clinical staff or peer supporters. One study (Dimidjian 2017) tested an individual BA intervention, which was delivered in person by healthcare professionals. Two studies (O'Mahen 2013 and O'Mahen 2014) were delivered during the postnatal period and Dimidjian 2017 was delivered during the prenatal period. The average number of BA sessions was either 10 or 11. One study (O'Mahen 2013) reported the average duration of BA sessions, which was 40 minutes long.

Reported outcomes included: anxiety symptoms, depressive symptoms, remission rate of depressive symptoms, perceived stress, behavioral and environmental measures, functional impairment, perceived available of social support, adherence to treatment, and satisfaction with treatment.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Table 6. Behavioral activation versus placebo light therapy for depressive disorders: Description of interventions and comparisons

Study, Year, PMID	Description of Behavioral Activation	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Dimidjian, 2017, 28045285 ⁹²	In-person individual treatment. Delivered by nurses, behavioral health interventionists or occupational therapists. Core treatment strategies included self-monitoring, structuring and scheduling activities, problem solving, and increasing social support. Sessions were structured and between-session homework was emphasized.	Usual care. If study assessments indicated an increase in depression severity, then the participant and obstetric provider was notified and a referral to behavioral health was made	10	NR	10 sessions over 10 weeks	Prenatal
O'Mahen, 2014, 24148703 ¹¹⁹	Online, self-guided intervention. 12-session treatment course consisted of a core BA module (five sessions) and a relapse prevention session. Women also chose two optional modules from a list of a possible six. All modules followed the BA functional analytical framework with interactive exercises. Participants had access to a chat room, moderated by peer supervisors. Weekly support calls were made by undergraduate trained clinical staff	Usual care. Women in both groups had access to a general depression chat room throughout the course of the study. This chat room is moderated by health visitors and parent supporters who provide email/chat room posting support and advice for depression.	12	NR	Self-paced	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of Behavioral Activation	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
O'Mahen, 2013, 23602514 ¹¹⁸	Online, self-guided intervention. The treatment focused on helping mothers achieve a balance in valued activities in the context of competing and unpredictable demands. This is accomplished through scheduling and reducing the frequency of negatively reinforced avoidant behaviors. Participants were sent weekly reminders to complete the homework tasks and had access to a private online chat room, moderated by peer supporters.	Usual care. Women in both groups had access to a general depression chat room throughout the course of the study. This chat room is moderated by health visitors and parent supporters who provide email/chat room posting support and advice for depression.	11	40 min	12 sessions over 15 weeks (self-paced)	Postnatal

Abbreviations: BA = behavioral activation, NR = not reported, PMID = PubMed identifier, TAU = treatment as usual.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.2.1 Risk of Bias

The most common concerns were related to the blinding of participants (1/3 high and 2/3 unclear risk of bias), detection bias (2/3 unclear risk of bias) and attrition bias (1/3 high, 1/3 unclear, and 1/3 low risk of bias). There was low risk of bias related to randomization, selection bias, and intention-to-treat analysis.

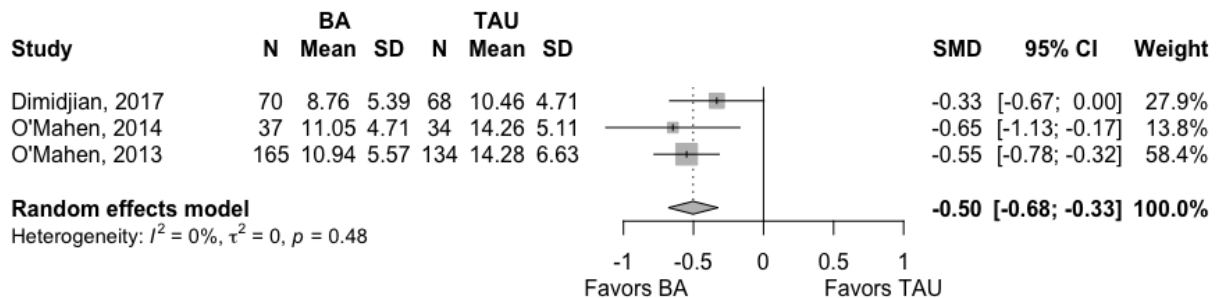
3.3.2.2.2 Anxiety Symptoms

One study (O'Mahen 2014) reported on participant's symptoms of anxiety at the end of treatment, using the GAD-7 (Appendix Table F-4). Participants in the BA group reported lower anxiety scores at the end of treatment compared with participants in the TAU group, but the difference was not statistically significant (SMD -0.50 , 95% CI -1.02 to 0.01), although this estimate is imprecise.

3.3.2.2.3 Depressive Symptoms

Three studies (Dimidjian 2017, O'Mahen 2014, and O'Mahen 2013) included measures of depressive symptoms at the end of treatment in 508 participants. Meta-analysis (Figure 5) provided evidence that depressive symptoms were significantly lower at the end of treatment among participants who had received behavioral activation compared with those who received TAU (summary SMD -0.50 , 95% CI -0.68 to -0.33 , I^2 0%).

Figure 5. Behavioral activation versus TAU for depressive disorders: Depressive symptoms



Abbreviations: BA = Behavioral Activation, TAU = Treatment as Usual, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval.

3.3.2.2.4 Remission Rate of Depressive Symptoms

One study (Dimidjian 2017) reported on the proportion of participants whose symptoms of depression reached remission at the end of treatment (Appendix Table F-5). Remission was defined as a score <5 on the Patient Health Questionnaire (PHQ-9). A greater proportion of participants in the BA group reached remission at the end of treatment compared with the TAU group (RR 1.61, 95% CI 1.03 to 2.53).

3.3.2.2.5 Perceived Stress

One study (Dimidjian 2017) reported on participants' perceived stress levels at the end of treatment and 3 months after the end of treatment (Appendix Table F-6). Perceived Stress Scale

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

(PSS) scores were lower in the BA group compared with the TAU group at end of treatment (SMD -0.56 , 95% CI -0.90 to -0.22) and 3-month followup (SMD -0.58 , 95% CI -0.93 to -0.22).

3.3.2.2.6 Behavioral and Environmental Measures

One study (Dimidjian 2017) reported on the Behavioral Activation for Depression Scale (BADs), which aims to measure changes in behaviors thought to underlie depression, and the Environmental Reward Observation Scale (EROS), which measures environmental reward and reinforcement of behaviors associated with depressive symptoms (Appendix Table F-7). Both the BADs and EROS scales are based on behavioral theories of depression and are aligned with principles of behavioral activation. BADs and EROS scores were collected at the end of treatment and 3 months after the end of treatment.

A higher score on the BADs at end of treatment indicates an improvement in BA behaviors. BADs scores were significantly higher in the BA group at end of treatment (SMD 0.51 , 95% CI 0.17 to 0.85) and 3-month followup (SMD 0.53 , 95% CI 0.19 to 0.87) compared with TAU. Similarly, a higher score on the EROS indicates greater environmental rewards and reinforcement of behaviors which are associated with reduced depressive symptoms. EROS scores were higher in the BA group at the end of treatment (SMD 0.56 , 95% CI 0.22 to 0.90) compared with TAU. However, there was no difference in EROS scores between the BA group and TAU at 3-month followup (SMD -0.51 , 95% CI -0.85 to -0.17).

3.3.2.2.7 Social Impairment

One study (O'Mahen 2014) reported on participants' social impairment at the end of treatment using the Work and Social Adjustment Scale (WSAS) (Appendix Table F-8). Participants who received BA had lower functional impairment at the end of treatment compared with participants who received TAU (SMD -0.57 , 95% CI -1.09 to -0.05).

3.3.2.2.8 Perceived Availability of Social Support

One study (O'Mahen 2014) reported on participants' perceived availability of social support at the end of treatment using the Social Provision Scale (Appendix Table F-9). There was no difference in perceived availability of social support at the end of treatment between participants who received BA compared with participants who received TAU (SMD 0.05 , 95% CI -0.01 to 1.03).

3.3.2.2.9 Adherence to Treatment

One study (Dimidjian 2017) reported on participants' adherence to BA by reporting on the number of treatment sessions completed. On average, participants completed 6.43 (standard deviation [SD] 3.64) BA sessions out of a total of 12 (Appendix Table F-10).

3.3.2.2.10 Satisfaction With Treatment

One study (Dimidjian 2017) reported on participants' satisfaction with BA using the Client Satisfaction Questionnaire (CSQ-8). Scores on the CSQ-8 range from 3 to 32, where a higher score indicates greater satisfaction with treatment. The mean CSQ-8 score among participants who received BA was 27.76 (SD 3.83) out of a possible total of 32 (Appendix Table F-11).

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.3 Bright Light Therapy Versus Placebo Light Therapy

Three studies compared bright light therapy to placebo light therapy in 143 participants. Table 7 presents a description of the interventions and comparisons used by the studies assessing the effectiveness of bright light therapy. Bright light therapy and placebo light were defined as 7,000 lux fluorescent bright white vs. 70 lux red (Wirz-Justice 2011), 9,000 lux color temperature 5000 K vs. 100 lux dim red 2700 K (Bais 2020), and 10,000 lux vs. dim <500 lux (Donmez 2022). The number of light therapy sessions ranged between 42 and 21. In each study, participants were asked to sit in front of the light box on a daily basis. The average duration of each light therapy session ranged between 30 and 60 minutes. All studies provided participants with light therapy boxes. The light therapy and placebo light therapy sessions were completed by participants in their own homes. All three studies included participants in the prenatal period.

Outcomes included depressive symptoms, remission rate of depression symptoms, response rate of depressive symptoms, and satisfaction with treatment.

Table 7. Bright light therapy versus placebo light therapy for depressive disorders: description of interventions and comparisons

Study, Year, PMID	Description of BLT	Description of PLT	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Bais, 2020, 33115894 ⁷⁸	9000 lux, color temperature 5000 K	100 lux, color temperature 2700 K	42	30 min	Daily	Prenatal
Donmez, 2022, 35339911 ⁹³	10,000 lux	<500 lux	21	45 min	Daily	Prenatal
Wirz-Justice, 2011, 21535997 ¹³⁴	7,000 lux white light	70 lux red light	35	60 min	Daily	Prenatal

Abbreviations: BLT = bright light therapy, PLT = placebo light therapy.

3.3.2.3.1 Risk of Bias

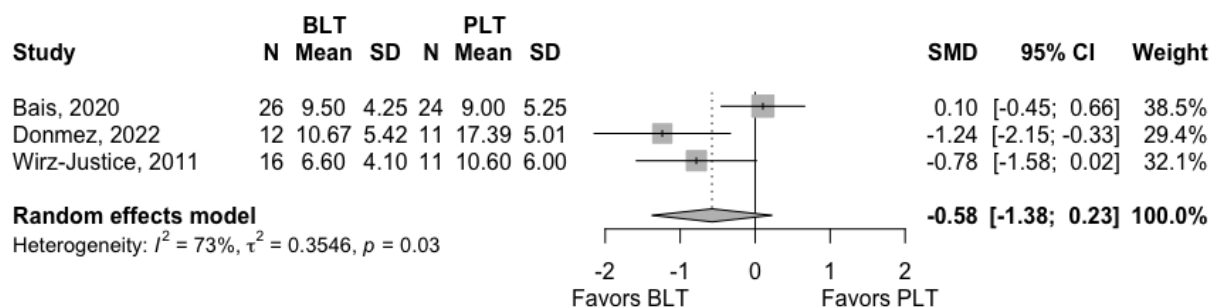
Specific concerns were related to allocation concealment (1/3 unclear and 2/3 low risk of bias), blinding of participants (1/3 high and 2/3 low risk of bias), blinding of outcome assessors (1/3 unclear and 2/3 low risk of bias), incomplete outcome reporting (1/3 high and 2/3 low risk of bias), and intention-to-treat analysis (1/3 high and 2/3 low risk of bias). All other domains were rated low risk of bias.

3.3.2.3.2 Depressive Symptoms

All three studies included measures of depressive symptoms at the end of treatment from 100 participants, total. Meta-analysis (Figure 6) provided insufficient evidence that depressive symptoms at the end of treatment did not differ significantly between participants who received bright light therapy and those who received placebo light therapy (summary SMD -0.58, 95% CI -1.38 to 0.23, I² 73%); The studies were inconsistent, with two favoring bright light therapy and one finding no difference, and lacking precision.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Figure 6. Bright light therapy versus placebo light therapy for depressive disorders: Depressive symptoms



Abbreviations: BLT = Bright Light Therapy, PLT = Placebo Light Therapy, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval.

3.3.2.3.3 Remission Rate of Depressive Symptoms

Two studies (Donmez 2022 and Wirz-Justice 2011) reported on the proportion of participants whose symptoms of depression reached remission at the end of treatment (Appendix Table F-12). Both studies included a score of 8 or below on the HAM-D as a definition of remission. There was no difference in remission rates between bright light or placebo light therapies. Donmez 2022 found RR 3.67 (95% CI 0.98 to 13.67); Wirz-Justice 2011 found 1.72 (95% CI 0.40 to 7.32), but the estimates were very imprecise, due to the low number of participants included in each study (27 and 23) and the low number of participants reaching remission in each group.

3.3.2.3.4 Response Rate of Depressive Symptoms

Two studies reported on the proportion of participants whose symptoms of depression, as rated by a validated scale, decreased by 50 percent or more at the end of treatment (Table F-13). Effect sizes ranged greatly between the two studies. Donmez 2022 found RR 4.58 (95% CI 0.63 to 33.37). Wirz-Justice 2011 found 2.06 (95% CI 0.90 to 4.74), but the estimates were very imprecise, due to the low number of participants included in each study (27 and 23) and the low number of participants experiencing a large response to treatment.

3.3.2.3.5 Satisfaction With Treatment

One study (Bais 2020) measured participants' satisfaction with treatment by asking them to rate, on a scale from 1 to 10, whether they would recommend treatment to others (Appendix Table F-14). Participants in the bright light therapy were no more likely to recommend treatment compared with participants in the placebo light therapy arm (SMD 0.08, 95% CI -0.40 to 0.56).

The same study also asked patients whether they would continue using light therapy (yes/no) (Appendix Table F-15). Bais 2020 reported on the percentage of participants in each group who reported they would continue using light therapy once the study ended. More participants in the placebo light therapy arm reported they would continue using light therapy (61.5%) than in the bright light therapy arm (57.1%) (RR 1.08). However, the study authors did not report the number of participants who responded to this outcome, precluding calculation of the confidence interval.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.4 CBT Versus Non-Directive Counseling

Three studies compared CBT to non-directive counseling in 226 participants (Table 8). Two tested an individual CBT intervention compared to an individual counseling intervention and one study compared group CBT to group or individual counseling. There was inconsistency in the reporting of the total number, average duration, and frequency of sessions. Two studies tested a 10-week CBT intervention compared to a 10-week counseling intervention. One study tested 9 weekly CBT sessions lasting 90 minutes to 9 weekly counseling sessions lasting 90 minutes. Two studies (Cooper 2023 and Milgrom 2005) stated that the CBT and counseling interventions were delivered by study therapists or mental health professionals, but did not give information on their professional backgrounds. The CBT and counseling interventions in the Hayden 2012 study were delivered by licensed social workers. Two studies (Cooper 2003 and Milgrom 2005) included participants in the postpartum period and Hayden 2012 included participants in the prenatal period.

Table 8. CBT versus non-directive counseling for depressive disorders: Description of interventions and comparisons

Study, Year, PMID	Description of CBT	Description of Counseling	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Cooper, 2003, 12724244 ¹³⁴	Individual CBT delivered by study therapists. Intervention focused on problems identified by the mother in the management of her infant (concerning, for example, feeding or sleeping), as well as on observed problems in the quality of the mother–infant interaction.	Individual counseling delivered by study therapists. Participants were provided with the opportunity to air their feelings about any current concerns, such as marital problems or financial difficulties, as well as concerns they might raise about their infant.	CBT = 10 weeks, Counseling = 10 weeks	CBT = NR, Counseling = NR,	CBT = NR, Counseling = NR	Postnatal
Hayden, 2012, 22526914 ¹⁰⁰	Individual CBT delivered by licensed social workers. Intervention focuses on identifying and eliminating maladaptive thoughts evident in major depressive disorders using traditional CBT techniques	Individual counseling delivered by licensed social workers. Directive and nonspecific support in the form of empathic listening and unconditional acceptance.	CBT = 10 Weeks, Counseling = 10 weeks	CBT = NR, Counseling = NR,	CBT = NR, Counseling = NR	Prenatal
Milgrom, 2005, 16368032 ¹¹³	Group CBT delivered by mental health professionals. Based on “Coping with Depression Course”, with additional partner sessions and modules on origins of family issues	Group or individual based counseling delivered by mental health professionals. Intervention included: supportive listening, history taking, problem clarification, goal formation, problem solving, partner sessions	CBT = 9, Counseling = 9	CBT = 90 min, Counseling = 90 min	CBT = weekly, Counseling = weekly	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, NR = not reported

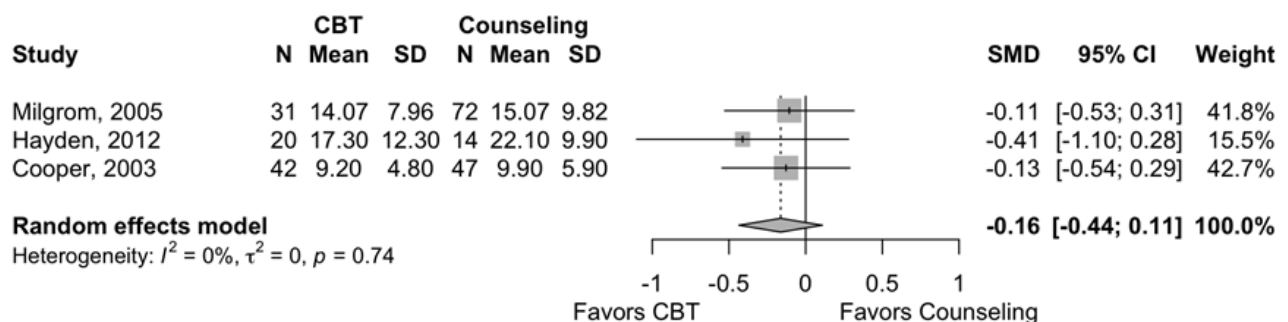
3.3.2.4.1 Risk of Bias

Specific concerns were related to the blinding of participants and personnel (3/3 high risk of bias) and allocation concealment (1/3 unclear and 2/3 unclear risk of bias). Blinding of outcome assessors, attrition bias, selective reporting, and intention-to-treat analysis were rated low risk of bias across all three studies.

3.3.2.4.2 Depressive Symptoms

Three studies included measures of depressive symptoms at the end of treatment among 226 participants. Meta-analysis (Figure 7) provided insufficient evidence that depressive symptoms at the end of treatment did not differ significantly between CBT group and counseling group (summary SMD -0.16 , 95% CI -0.44 to 0.11 , I^2 0%). Effect sizes were consistent between studies but imprecise.

Figure 7. CBT versus counseling for depressive disorders: Depressive symptoms at the end of treatment



Abbreviations: CBT = cognitive behavioral therapy, SD = standard deviation, SMD = standardized mean difference, 95% CI = 95% confidence intervals.

3.3.2.4.3 Remission Rate of Depressive Symptoms

One study (Cooper 2003) reported on the proportion of participants whose symptoms of depression, as rated by a validated scale, remitted at the end of treatment (Appendix Table F-16). There was no difference in the proportion of participants who reached remission for depressive symptoms at the end of treatment between the CBT and counseling groups (RR 1.05 95% CI 0.73 to 1.53).

3.3.2.4.4 Anxiety Symptoms

One study (Milgrom 2005) reported on whether anxiety symptoms improved at the end of the intervention using the Beck Anxiety Inventory (BAI) (Appendix Table F-17). There was no difference in anxiety symptoms between the CBT and counseling groups (SMD -0.05 , 95% CI -0.47 to 0.37).

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.4.5 Parent-Infant Bonding

One study (Cooper 2003 [reported in Murray 2003]¹⁷⁸) reported on the parent-infant bond using two measures 1) self-reported of bonding issues, 2) Ainsworth's attachment types which was used to identify the proportion of participants with secure versus insecure attachment types (Appendix Tables F-18 and F-19). A lower proportion of participants in the CBT group reported bonding issues compared with the counseling group (RR 0.57, 95% CI 0.35 to 0.95). However, the proportion of participants with secure attachment types was similar between the CBT and counseling groups (RR 1.31, 95% CI 0.82 to 2.11) between the CBT and counseling groups.

3.3.2.4.6 Child Behavioral and Emotional Difficulties

Two studies (Cooper 2003 [reported in Murray 2003]¹⁷⁸ and Hayden 2012) assessed child behavioral and emotional difficulties, using various scales (Appendix Table F-20).

Cooper 2003 assessed behavioral and emotional difficulties on the Behavioral Screening Questionnaire (BSQ), which captured maternal reported of behavioral issues at 72 weeks (18 months) postpartum; the Rutter A² scale, which captured parental reports of behavioral difficulties at 5 years postpartum; and the Pre-School Behavioral Checklist (PBCL), which captured teacher reported behavioral difficulties five years postpartum. On all three measures, a higher score indicates greater behavioral difficulties.

Cooper 2003 reported that children of participants in the CBT group had similar scores on BSQ, indicating greater behavioral difficulties, compared with children of participants in the counseling group (CBT Median 5 [Range 0 to 13] vs. Counseling Median 4, Range 0 to 11), with a median difference of 1. The authors reported that this difference was statistically significant ($P = 0.03$). At 5 years, children whose mothers had received CBT reported similar scores on the Rutter A² compared with children of mothers in counseling group (median 8 [range 0 to 16] vs. 9 [3 to 33]), with a median difference of -1 (range not reported). The authors reported this difference was not statistically significant ($P = 0.07$). Similarly, there was no differences in behavioral difficulties as measured by the PBCL between the CBT and counseling groups (Median 4 [range 0 to 11] vs. 3 [range 0 to 14]), with median difference of 1 (range not reported) ($P = 0.99$).

Hayden 2012 reported that infants of participants treated with CBT were rated significantly higher on the Behavioral Rating Scale (BRS), which indicates fewer behavioral issues, than infants of participants treated with counseling (56.1 percentile vs. 29.6 percentile). The authors reported that this difference was statistically significant ($p < 0.05$).

3.3.2.4.7 Infant and Child Cognitive Development

One study (Cooper 2003 [reported in Murray 2003]¹⁷⁸) included measures of infant and child cognitive development (Appendix Table F-21). They measured infant cognitive development by using the Mental Development Index of the Bayley scales for Infant Development at 72 weeks (or 18 months). The Bayley scales are norm-referenced, where infants are rated against the performance of their peers. Infants with significantly lower scores than their peers may be developmentally delayed. Children of participants in the CBT group reported similar scores compared with counseling (CBT median 114 [64 to 150] vs. counseling 116 [range 73 to 150]), with a median difference of 2. The authors reported there was no statistical difference in Mental

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Development Index scores between the CBT and counseling groups, with a reported p-value of 0.85.

The same study also measured child cognitive development at 5 years using the General Cognitive Index of the McCarthy Scale. Scores on the Global Cognitive Index are standardized, with a mean of 100 and standard deviation of 16. Children of participants in both groups had median scores above average (CBT median 107 [54 to 148] vs. counseling 111 range [69 to 145]), with a median difference of 4. The authors reported there was no statistical difference in scores on the Global Cognitive Index between the groups, with a reported p-value of 0.91.

3.3.2.5 CBT Versus TAU

There were 28 studies that compared CBT with TAU among participants with depressive disorders. There was variety in the mode of delivery and setting of studies comparing CBT with TAU (Table 9). Most interventions (22/28, 79%) were delivered by mental health or study professionals, 4/28 (14%) interventions were self-guided, and 2/28 (7%) were delivered by peer supporters. Most studies (19/18, 68%) recruited participant during the postnatal period, five studies (18%) included participants in the prenatal period and four (14%) studies included both prenatal and postnatal participants. The plurality (11/26, 42%) of CBT interventions were individual CBT programs. Most individual CBT interventions were delivered in the clinic, however four were delivered in the participant's home (Ammerman 2003, Burns 2013, Cooper 2003, and O'Mahen 2013). Ten studies tested a group CBT intervention. Two group CBT interventions were delivered as one-time workshops, which each lasted 7 hours (Van Lieshout 2021 and Van Lieshout 2023). Five studies tested a self-guided CBT intervention, which was typically delivered via an online platform. Two 9-week group CBT interventions were delivered remotely via zoom, one was facilitated by a mental health nurse (Huh 2023) and one was facilitated by peer supporters (Merza 2023). One study tested a self-guided intervention where participants were mailed CBT workbooks and instructional videos (Wozney 2017). With the exception of the two one-time workshops, CBT interventions ranged between 5 and 21 sessions and lasted between 30 and 120 minutes. Usual care was typically described as access to locally available care.

Outcomes included depressive symptoms, remission rate of depressive symptoms, anxiety symptoms, quality of life, stress (perceived stress and parenting stress), quality of relationships, provision of social support, social functioning, parent-infant bonding (fetal and postpartum), child cognitive development and child behavioral, child cognitive development and emotional difficulties.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Table 9. CBT versus TAU for depressive disorders: Description of interventions and comparisons

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Alhusen, 2021, 32409986 ⁷⁴	Group CBT delivered by trained facilitators. Sessions were divided into modules that mapped onto core CBT concepts. Each session included didactic instruction on core concepts as well as activities and group discussions.	Usual care	6	120 minutes	Weekly	Prenatal
Amani, 2021, 34758210 ⁷⁵	Group CBT delivered by peer supporters. Incorporated cognitive skills (e.g., cognitive restructuring) and behavioral techniques (behavioral activation, relaxation, goal-setting)	Usual care	9	120 minutes	Weekly	Postnatal
Ammerman, 2013, 23768664 ⁷⁶	In-home individual CBT delivered by Masters-level social workers. Based on core CBT principles	Usual care	15 + 1 booster session after end of treatment	60 minutes	Weekly	Postnatal
Burns, 2013, 23339584 ⁸²	In-home individual CBT with Masters-level or Doctoral-level CBT therapists. Adaptations for perinatal population included paying attention to the role of maternal beliefs, the unique environmental constraints surrounding behavioral activation and incorporating principles and strategies that address the ways to improve communication and social support.	Usual care.	12	NR	NR	Prenatal
Cho, 2008, 18729297 ⁸⁵	Individual CBT delivered by licensed CBT therapist. Additional components about marital relationships included promoting acceptance through better understanding of the personalities of their spouses and communication skills.	Usual care	15	60 minutes	Biweekly	Prenatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Cooper, 2003, 12724244 ⁸⁶	Individual CBT delivered by study therapists. The treatment was primarily directed not at the maternal depression itself but at problems identified by the mother in the management of her infant, as well as at observed problems in the quality of the mother–infant interaction.	Usual care	10	NR	Weekly	Postnatal
Danaher, 2023, 36174746 ⁹⁰	Online self-guided CBT app. Included content on increasing pleasant activities to regain life balance, interrupting negative and increasing positive thoughts, seeking support from others, and tracking mood.	Usual care. Participants had access to a referral network of community mental health providers, a 24/7 crisis hotline to respond to urgent and emergent needs provided by their local health service	6	NR	Self-paced (complete all sessions in 12 weeks)	Prenatal and postnatal
Forsell, 2017, 28628768 ⁹⁵	Online self-guided CBT. An adapted version of the internet-based CBT (iCBT) for depression	Waitlist control, with routine care	10 weeks	NR	Self-paced	Prenatal
Honey, 2002, 12437794 ¹⁰¹	Group CBT delivered by health visitors. Intervention consisted of providing information on postnatal depression, strategies for coping with difficult child-care situations and eliciting social support, use of cognitive–behavioral techniques to tackle women's erroneous cognitions about motherhood and provide strategies for coping with anxiety, and the use of relaxation	Usual care	8	60 minutes	Weekly	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Huh, 2023, 37498661 ¹³⁹	Group CBT via Zoom by CBT professionals. Intervention covered core CBT content (e.g., cognitive restructuring) along with psychoeducation related to maternal mental health. The intervention followed a manual. Facilitated by mental health nurses.	Usual care. Including access to locally available services.	9	120 minutes	Weekly	Postnatal
Husain, 2023, 37413896 ¹⁰²	Culturally adapted group CBT delivered by study therapists. Adapted to the needs of British South Asians	Usual care. Might include physician-suggested self-help strategies, therapy, and medications	12	90 minutes	Weekly	Postnatal
Leung, 2016, 26908335 ¹⁰⁴	Group CBT delivered by mental health professionals. Aimed to change cognitions and subsequently reinforce coping skills to enhance psychological resources and responses. CBT-guided participants to proactively respond to stress by reducing their negative thoughts	Routine care	6	120 minutes	Weekly	Postnatal
Merza, 2023, 37649448 ¹⁴²	Group CBT via Zoom facilitated by peer supporters. Intervention covered core CBT content (e.g., cognitive restructuring) along with psychoeducation related to maternal mental health. The intervention followed a manual.	Usual care. Including access to locally available services.	9	120 minutes	Weekly	Postnatal
Milgrom, 2005, 16368032 ¹¹³	Group CBT delivered by mental health professionals. Adapted from 'coping with depression' program. Incorporates partner sessions	Usual care	9	90 minutes	Weekly	Postnatal
Milgrom, 2011, 21615968 ¹¹²	Individual CBT, delivered by psychologist or nurse.	Usual care by primary care physician	6	NR	Weekly	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Milgrom, 2015, 25709044 ¹¹¹	Individual CBT delivered by mental health professional. Adaptation of 'Coping with Depression Course'. Incorporates: behavioral activation (increasing pleasant activities), cognitive strategies, relaxation 'on the run' techniques, increasing social networks, partner sessions and addressing infant issues	Usual care	8	60 minutes	NR	Prenatal
Milgrom, 2016, 26952645 ¹¹⁰	Online, self-guided CBT. Program called "MumMoodBooster". Online interactive sessions with print out options and self-monitoring tools. Participants had access to an online forum where they could talk to other study participants. Telephone support was provided by a coach	Usual care. Primary care physicians for the usual care group were notified of the participants' depressive diagnosis	6	NR	Self-paced	Postnatal
Ngai, 2015, 26278623 ¹¹⁵	Telephone-based CBT delivered by midwives. Teaching methods to identify and modify depressogenic thoughts, increase pleasant activities, enhance effective problem-solving strategies and decision-making skills, and manage interpersonal difficulties through improving communication and negotiation skills	Usual care	5	NR	Weekly	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
O'Mahen, 2013, 23319454 ¹¹⁸	Individual CBT modified for racially diverse, low-income women. Delivered by Masters- and Doctoral-level social workers and psychologists. Treatment started with an engagement session informed by motivational interviewing. Core concepts included behavioral activation, cognitive restructuring and interpersonal support	Usual care. Participants were provided feedback on their depression diagnosis by study social worker and were given educational materials	12	50 minutes	NR	Prenatal and postnatal
Pearson, 2013, 22884235 ¹²¹	Individual CBT delivered in the participant's home by a clinical psychologist. Core concepts included behavioral activation, cognitive restructuring and interpersonal support	Usual care	9 to 12	NR	NR	Prenatal and postnatal
Prendergast, 2001 ¹³⁶	Group CBT delivered by early childhood nurses. Included detailed psychoeducation, cognitive monitoring and thought challenging diaries and modules on anxiety management, assertiveness training, self-esteem and pleasant-event scheduling	Usual care	6	60 minutes	Weekly	Postnatal
Pugh, 2016, 26930488 ¹²²	Online self-guided CBT, supported by a therapist.	Waitlist control. Provided with educational materials and signposted to mental health services	7	NR	Self-paced	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Trevillion, 2020, 31634678 ¹²⁷	Individual CBT – based on the principles of guided self-help. Delivered by mental health professionals. Included information on education about prenatal depression, managing relationships, planning for parenthood, health and lifestyle factors	Usual care	8	30 minutes	NR	Prenatal and Postnatal
Van Lieshout, 2021, 34495285 ¹²⁹	1-day online group CBT workshop delivered by a psychotherapist, clinical psychology student, or psychiatrist. Core concepts included: cognitive risk factors for depression, cognitive restructuring, problem solving, behavioral activation, and goal setting	Usual care	1	7 hours	One time	Postnatal
Van Lieshout, 2022, 35060398 ¹³⁰	Group CBT delivered by nurses. Core CBT concepts and educational information and group discussion.	Usual care	9	120 minutes	Weekly	Postnatal
Van Lieshout, 2023, 36878891 ¹³¹	1 day in-person group CBT workshop delivered by psychiatrist or psychotherapist. Core concepts included: cognitive risk factors for depression, cognitive restructuring, problem solving, behavioral activation, and goal setting	Usual care	1	7 hours	One time	Postnatal
Wiklund, 2010, 20636249 ¹³³	Individual CBT-based counseling delivered by CBT therapist. The intervention focused on behavioral strategies for coping with depression.	Usual care	21	60 minutes	Three times a week	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Wozney, 2017, 28593360 ¹³⁵	Remote CBT delivered by CBT coach. Participants were mailed an intervention workbook and videos to complete. Participants received weekly support calls from a coach	Usual care. Participants received psychoeducational leaflets	12	NR	Weekly	Postnatal

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, NR = not reported

3.3.2.5.1 Risk of Bias

The most common concerns were related to the blinding of participants and personnel (24/28 high and 4/28 unclear risk of bias), randomization procedures (6/28 unclear and 22/28 low risk of bias), blinding of outcome assessors (2/28 high, 11/28 unclear, and 15/28 low risk of bias), and allocation concealment (1/28 high, 11/28 unclear, and 16/28 low risk of bias). All other domains were rated low risk of bias.

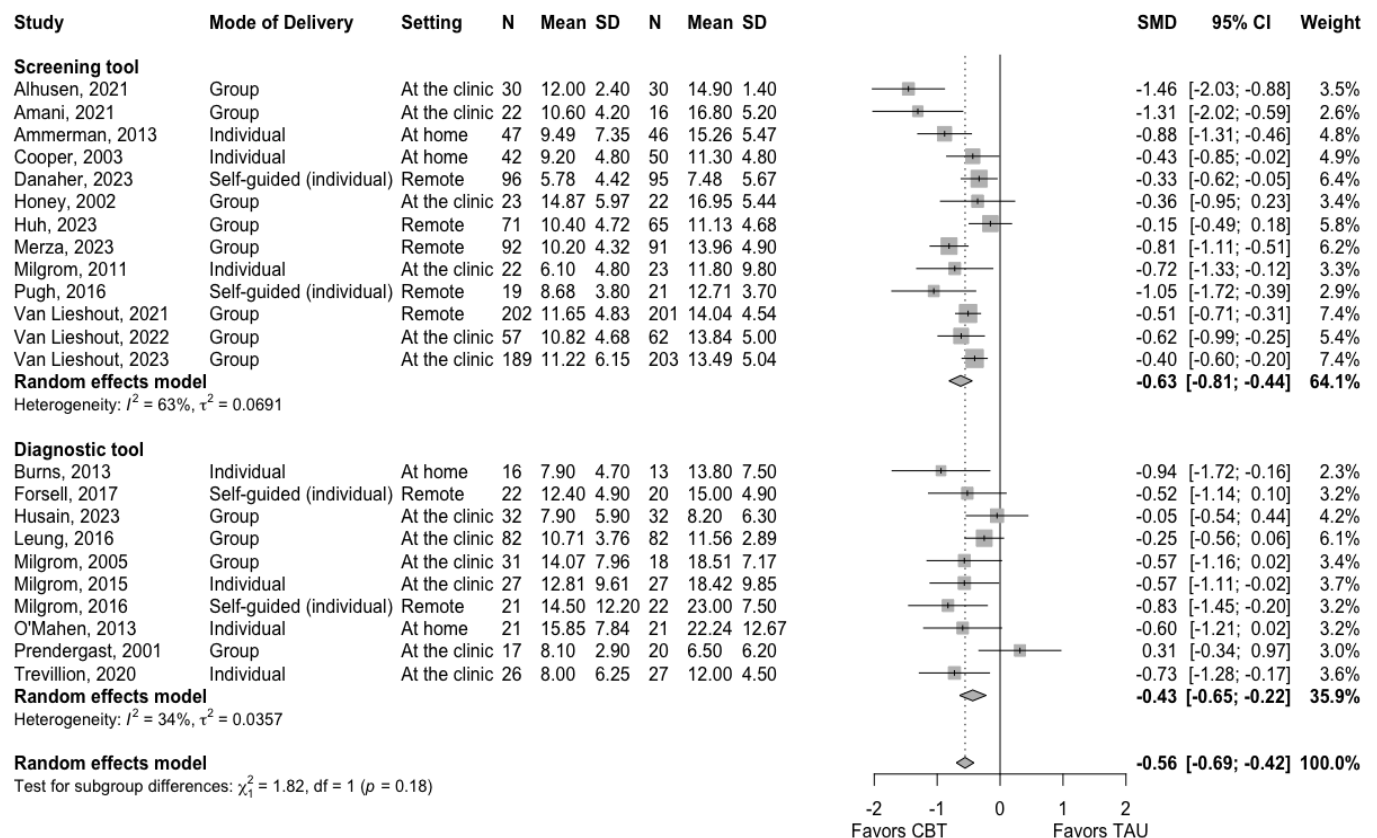
3.3.2.5.2 Depressive Symptoms

Twenty-seven studies included measures of depressive symptoms at the end of treatment, but four of them (Cho 2008, Ngai 2015, Wiklund 2010 and Wozney 2017) were missing key outcome data and were excluded from analysis. Cho 2008 did not report raw BDI scores with standard deviations. Ngai 2015 also did not report raw EPDS scores, they reported mean differences stratified by minor versus major depression at baseline without reporting the number of participants in each severity subgroup. Wiklund 2010 reported raw EPDS scores but did not provide the standard deviation. Wozney 2017 reported raw BDI scores at the end of treatment but did not include standard deviations. Studies not included in the meta-analysis were consistent with studies that were. Cho 2008, Ngai 2015, Wiklund 2010 and Wozney 2017 all reported that CBT was more effective than TAU at treating depressive symptoms.

Studies used differing eligibility criteria to confirm a depression diagnosis at enrollment. Ten studies used a structured diagnostic tool based on clinical criteria (i.e. the Structured Clinical Interview for the DSM [SCID]) and 13 studies used a screening tool (e.g. the EPDS or BDI). Across tools used to confirm a depression diagnosis, meta-analysis of data from 23 studies and 2,414 participants (Figure 8) provided evidence that depressive symptoms were significantly lower at the end of treatment among participants who had received CBT compared with those who received TAU (summary SMD -0.56 , 95% CI -0.69 to -0.42 , I^2 54%). There was moderate statistical heterogeneity across studies, but studies were very consistent in finding improvement in depressive symptoms with CBT; although the magnitude of the relative improvement varied across studies.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Figure 8. CBT versus TAU for depressive disorders: Depressive symptoms at the end of treatment by diagnostic or screening tool used at enrollment



Abbreviations: CBT = cognitive behavioral therapy, CI = confidence intervals, SD = standard deviation, SMD = standardized mean difference, TAU = treatment as usual.

3.3.2.5.2.1 Diagnostic Criteria Subgroup Analysis

We examined whether there were any differences in depressive symptoms at the end of treatment between studies using diagnostic or screening tools to assess depressive symptoms at enrollment. While depressive symptoms improved somewhat more with CBT among studies that enrolled participants based on a screening tool (summary SMD -0.63 95% CI -0.81 to -0.44) than among studies that enrolled participants based on a diagnostic tool (summary SMD -0.43 , 95% CI -0.65 to -0.22). This difference was not statistically significant, based on meta-regression ($P = 0.23$).

3.3.2.5.2.2 CBT Delivery Mode Subgroup Analysis

We compared studies that used different modes of CBT, including group, individual therapist led, and individual self-guided CBT. The subgroup meta-analyses are summarized in Table 10. Where group CBT was the reference Based on meta-regression, there were no significant differences in the SMD of depressive symptoms at the end of treatment across the different modes of delivery ($P = 0.51$).

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Table 10. CBT versus TAU for depressive disorders: Depressive symptoms by CBT delivery mode

Mode of Delivery	K	SMD (95% CI)
Group	12	-0.49 (-0.73, -0.26)
Individual (therapist led)	7	-0.67 (-0.87, -0.47)
Individual (self-guided)	4	-0.60 (-0.94, -0.25)

Note: all differences are statistically significant.

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, K = number of studies, SMD = standardized mean difference, CI = confidence interval.

3.3.2.5.2.3 CBT Delivery Setting Subgroup Analysis

We compared studies that delivered CBT in different settings, including in the clinic, in the participant's home, or delivered remotely (via telephone, video-calls or text-based programs). The subgroup meta-analyses are summarized in Table 11. Based on meta-regression, there were no significant differences in the SMD of depressive symptoms at the end of treatment across the different modes of delivery ($P = 0.75$).

Table 11. CBT versus TAU for depressive disorders: Depressive symptoms by delivery setting

Setting	K	SMD (95% CI)
In the clinic	12	-0.54 (-0.79, -0.29)
In the participant's home	4	-0.68 (-0.95, -0.40)
Remote	7	-0.54 (-0.76, -0.33)

Note: all differences are statistically significant.

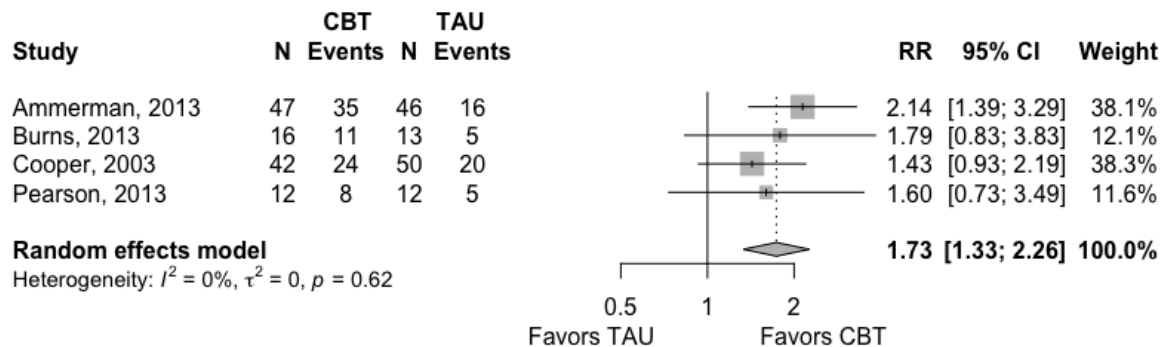
Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, K = number of studies, SMD = standardized mean difference, CI = confidence interval.

3.3.2.5.3 Remission Rate of Depressive Symptoms

Five studies reported on the rate of remission of depressive symptoms at the end of treatment. All studies used the SCID to measure remission of depressive symptoms. One study (Wozney 2017) reported odds ratios comparing remission rates between the CBT and TAU groups, they did not report the number of or proportion of participants in each group who reached remission. Consistent with the meta-analysis, Wozney 2017 reported that the odds of remission were higher in the treatment group. Meta-analysis (Figure 9) provided evidence that rates of remission were higher in the CBT group compared with the TAU group (summary RR 1.73, 95% CI 1.33 to 2.26, I^2 0%).

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Figure 9. CBT versus TAU for depressive disorders: Remission of depressive symptoms at the end of treatment

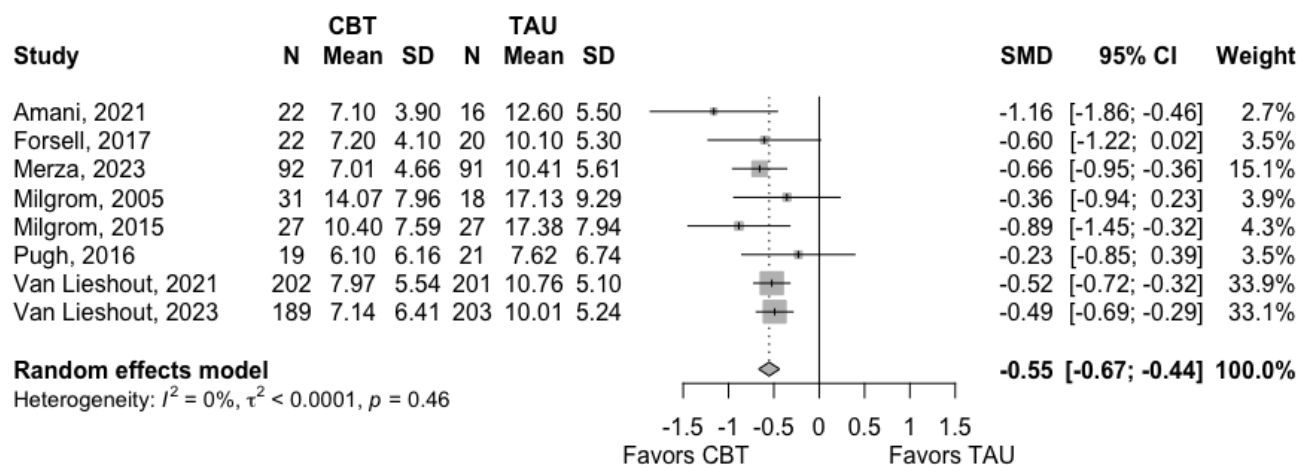


Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, RR = relative risk, CI = confidence interval.

3.3.2.5.4 Anxiety Symptoms

Eight studies included measures of anxiety symptoms at the end of treatment. Meta-analysis of data from 1,201 participants (Figure 10) provided evidence that symptoms of anxiety were significantly lower in the CBT group at the end of treatment, compared with the TAU group (summary SMD -0.55 , 95% CI -0.67 to -0.44 , $I^2 0\%$).

Figure 10. CBT versus TAU for depressive disorders: Remission of anxiety symptoms at the end of treatment



Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval.

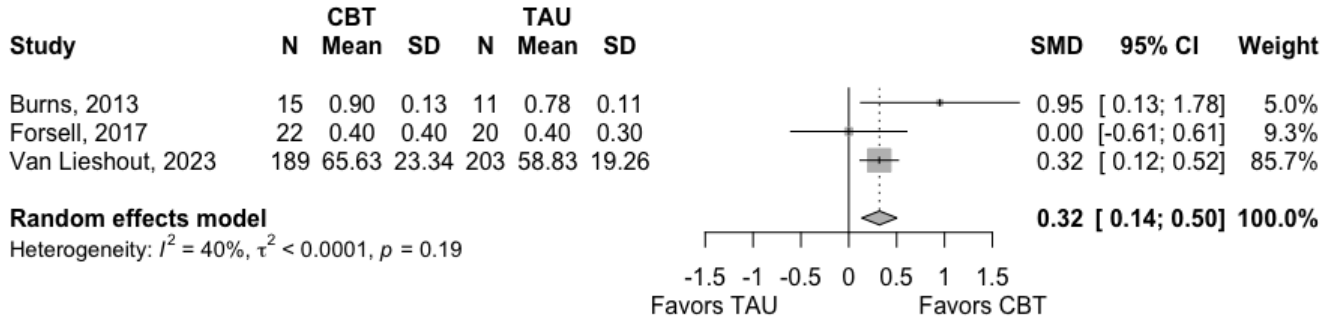
3.3.2.5.5 Quality of Life

Three studies (Burns 2013, Forsell 2017, and Van Lieshout 2023) included measures of quality of life at the end of treatment. Two studies (Burns 2013 and Forsell 2017) measured quality of life using the Euroqol-5 Dimensions (EQ-5D) utility instrument. One study (Van Lieshout 2023) measured quality of life using the EQ-5D visual analogue scale. Meta-analysis (Figure 11) provided evidence that quality of life scores were significantly higher, indicating

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

better quality of life, in the CBT group compared with the TAU group (summary SMD 0.32, 95% CI 0.14 to 0.50, I^2 40%); although the summary estimate largely recapitulates Van Lieshout 2023, the largest study.

Figure 11. CBT versus TAU for depressive disorders: Quality of life (EQ-5D)



Abbreviations: EQ-5D = EuroQol-5 Dimensions, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval.

3.3.2.5.6 Stress (Perceived Stress and Parenting Stress)

One study (Pugh 2016) measured perceived stress using the Stress Subscale from the Depression, Anxiety, Stress Scale (DASS) (Appendix Table F-22). Participants in the CBT group reported lower perceived stress scores at the end of treatment compared with the TAU group (SMD -0.96 , 95% CI -1.61 to -0.30).

Pugh 2016 also measured parenting related stress at the end of treatment using the short form of the Parenting Stress Index (PSI). The PSI comprises of three subscales, which are reported separately: parental distress, parent-child dysfunctional interaction, perception of a difficult child. There were no differences in parental distress (SMD -0.55 , 95% CI -1.18 to 0.08), parent-child dysfunctional interaction (SMD -0.56 , 95% CI -1.19 to 0.08), or perception of a difficult child (SMD -0.31 , 95% CI -0.94 to 0.08) between the CBT and TAU groups (Appendix Table F-23).

3.3.2.5.7 Quality of Relationships

One study (Cho 2008) included two measures of the quality of the relationship between the mother and her partner; these two measures assess the participant's dissatisfaction with communication and marital dissatisfaction. Both were assessed using Snyder's Marital Satisfaction Inventory). Dissatisfaction with communication scores (SMD -0.91 , 95% CI -1.79 to -0.03) and marital dissatisfaction scores (SMD -1.69 , 95% CI -2.67 to -0.79) were lower in the CBT group compared with TAU (Appendix Table F-24).

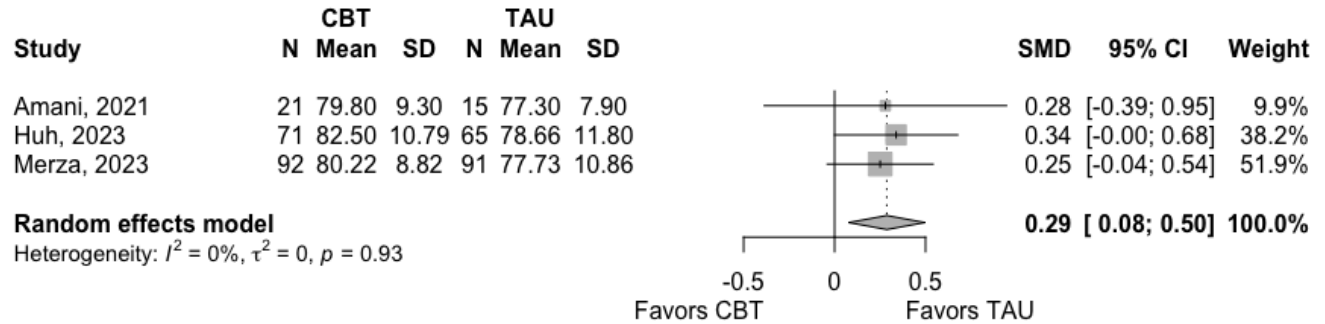
3.3.2.5.8 Availability of Social Support

Three studies (Amani 2021, Huh 2023, and Merza 2023) measured the perceived availability of social support using the social provision scale (SPS), where a higher score indicates greater social support. Meta-analysis (Figure 12) provided evidence SPS scores were higher in the CBT group compared with TAU (summary SMD 0.29 , 95% CI 0.08 to 0.50 , I^2 0%). Studies were

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

consistent, but imprecise. The summary estimate was also imprecise, however we detected little heterogeneity across studies.

Figure 12. CBT versus TAU for depressive disorders: Availability of social support



Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval.

3.3.2.5.9 Social Functioning

One study (Forsell 2017) measured the impact of the participants symptoms on their social functioning using the WSAS (Appendix Table F-25), where a higher score indicates more impaired social functioning. There was no difference in social functioning (SMD -0.49 , 95% CI -1.10 to 0.13) between the CBT and TAU groups.

3.3.2.5.10 Adherence to Treatment

One study (Ammerman 2013) reported on two measures of adherence to CBT treatment: the average number of sessions completed and the proportion of participants who completed all sessions (Appendix Tables F-26 and F-27). The mean number of CBT sessions completed was 11.2 (SD 5.5) and 53.0% of participants completed all treatment sessions.

3.3.2.5.11 Parent-Infant Bonding (Fetal and Postpartum)

Two studies (Alhusen 2021 and Burns 2013) measured the parent-infant bond before birth (maternal-fetal attachment) using the Maternal Fetal Attachment Scale (MFAS) and the Prenatal Attachment Inventory (PAI), respectively. For both the MFAS and the PAI, a higher score indicates a better parent-infant bond. We found conflicting evidence regarding the effect of CBT on maternal-fetal attachment scores. Alhusen 2021 reported maternal-fetal attachment scores were higher in the TAU group compared with the CBT group (SMD -0.72 , 95% CI -1.24 to -0.20). However, Burns 2013 reported maternal fetal-attachment scores were higher in the CBT group (SMD 4.10 , 95% CI 2.71 to 5.50) (Appendix Table F-28).

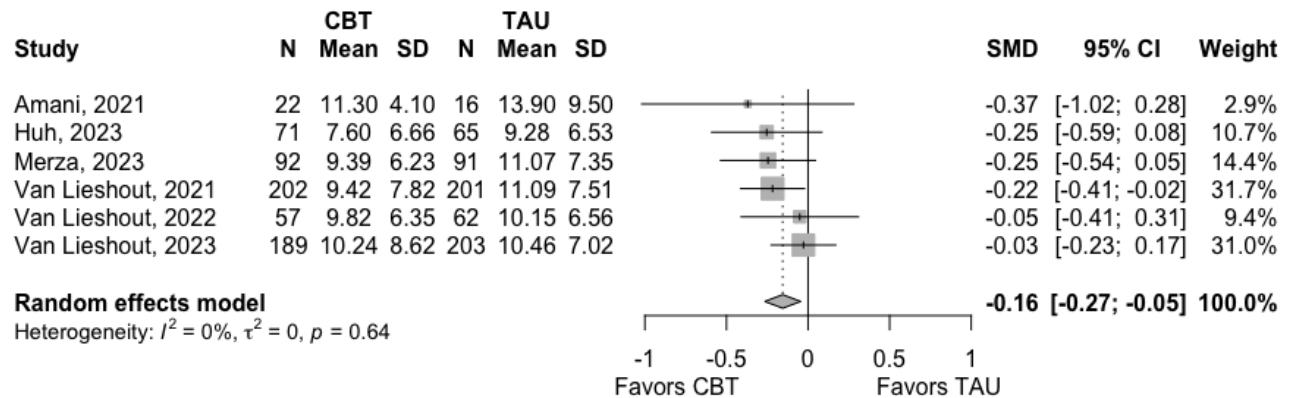
Six studies reported measures of parent-infant bonding after the birth of the infant using the Postpartum Bonding Questionnaire (PBQ). The PBQ comprises three subscales, each assessing different aspects of the parent-child bond: impaired bonding, infant anxiety, and rejection/anger. We conducted separate analyses for each of these subscales.

Meta-analyses provided evidence of a significant difference in PBQ impaired bonding scores (summary SMD -0.16 , 95% CI -0.27 to -0.05 , I^2 0%; Figure 13), PBQ infant anxiety scores (summary SMD -0.26 , 95% CI -0.37 to -0.15 , I^2 0%; Figure 14), and PBQ anger/rejection

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

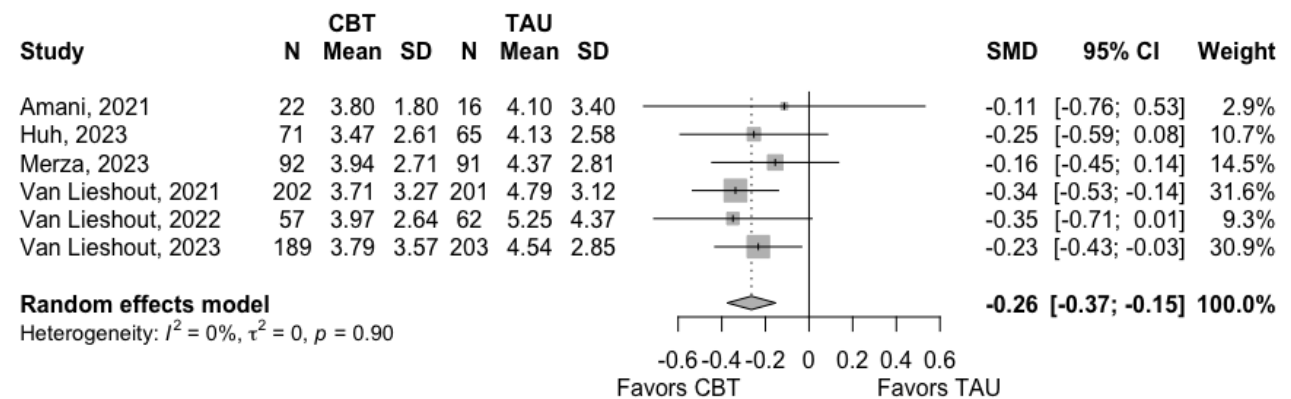
scores (summary SMD -0.13 , 95% CI -0.24 to -0.02 , I^2 0%; Figure 15) between the CBT and TAU groups. However, across each of these meta-analyses, the results from individual studies were generally consistent but the individual and summary estimates were imprecise.

Figure 13. CBT versus TAU for depressive disorders: PBQ impaired bonding at the end of treatment



Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, PBQ = Postpartum Bonding Questionnaire, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval.

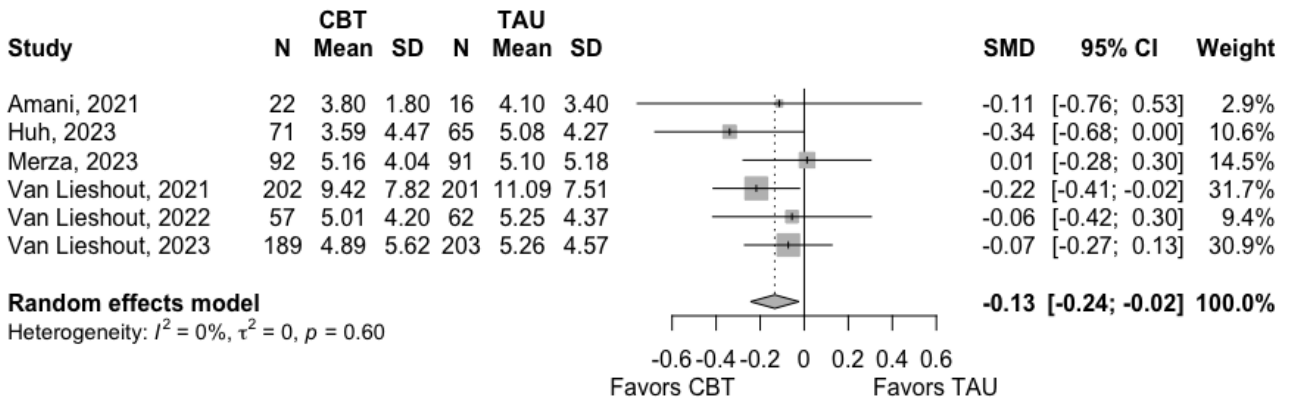
Figure 14. CBT versus TAU for depressive disorders: PBQ infant anxiety at the end of treatment



Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, PBQ = Postpartum Bonding Questionnaire, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Figure 15. CBT versus TAU for depressive disorders: PBQ rejection/anger at the end of treatment



Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, PBQ = Postpartum Bonding Questionnaire, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval.

3.3.2.5.12 Infant and Child Cognitive Development

One study (Cooper 2003 [reported in Murray 2003]¹⁷⁸) included measures of infant and child cognitive development (Appendix Table F-29). They measured infant cognitive development by using the Mental Development Index of the Bayley scales for Infant Development at 72 weeks (or 18 months). The Bayley scales are norm-referenced, where infants are rated against the performance of their peers. Infants with significantly lower scores than their peers may be developmentally delayed. Children of participants in the CBT group reported similar scores compared with TAU (CBT median 114 [range 64 to 150] vs. TAU median 116 [58 to 150]), with a median difference of 2. The authors reported there was no statistical difference in Mental Development Index scores between the CBT and counseling groups ($P = 0.85$).

The same study also measured child cognitive development at 5 years using the General Cognitive Index of the McCarthy Scale. Scores on the Global Cognitive Index are standardized, with a mean of 100 and standard deviation of 16. Children of participants in both groups had median scores above average (CBT median 107 range [54 to 148] vs. counseling 108 [50 to 140]), with a median difference of 4. The authors reported there was no statistical difference in scores on the Global Cognitive Index between the groups ($P = 0.91$).

3.3.2.5.13 Child Emotional and Behavioral Difficulties

One study (Cooper 2003 [reported in Murray 2003]¹⁷⁸) included measures of child behavioral and emotional difficulties (Appendix Table F-30). Measures included the Rutter A² scale, which captured parental reports of behavioral difficulties at 5 years postpartum; the PBCL, which captured teacher reports of behavioral difficulties 5 years postpartum. On all three measures, a higher score indicates greater behavioral difficulties.

At 5 years, children whose mothers had received CBT reported similar scores on the Rutter A² compared with children of mothers in counseling group (median 8 [range 0 to 16] vs. 11 [1 to 28]), with a median difference of 3 (range not reported). The authors reported this difference was not statistically significant ($P = 0.07$). Similarly, there was no differences in behavioral difficulties as measured by the PBCL between the CBT and counseling groups (Median 4 [range 0 to 11] vs. 3 [range 0 to 14]), with median difference of 1 (range not reported) ($P = 0.99$).

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.6 Non-Directive Counseling Versus TAU

Three studies compared non-directive counseling to TAU in 247 participants (Table 12). Two studies tested individual counseling interventions compared with treatment as usual. In one study the counseling group was assigned to either group or individual counseling, this study presents outcomes pooled between participants who received group and individual counseling. The counseling interventions primarily consisted of active and reflective listening and problem solving. Two studies compared counseling to the usual care provided by local services and one study compared counseling to a waitlist control (where participants still had access to usual care). All counseling interventions were delivered by mental health or study professionals. Two studies (Milgrom 2005 and Cooper 2003) included participants during the postnatal period. Segre 2015 included participants in the prenatal and postnatal period.

Outcomes included: anxiety symptoms, child emotional and behavioral difficulties, depressive symptoms, infant behavior, infant cognition, maternal sensitivity, quality of life, social adversity, social functioning, wellbeing, response rate of depressive symptoms, remission rate of depressive symptoms, and parent-infant bonding.

Table 12. Counseling versus TAU for depressive disorders: Description of interventions and comparisons

Study, Year, PMID	Description of Counseling	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Milgrom, 2005, 16368032	Group or individual based counseling delivered by mental health professionals. Intervention included: supportive listening, history taking, problem clarification, goal formation, problem solving, partner sessions	Usual care. Participants received the normal care provided by the primary healthcare team (i.e. general practitioners and health visitors)	9	90 min	Weekly	Postnatal
Cooper, 2003, 12724244	Individual counseling delivered by study therapists. Participants were provided with the opportunity to air their feelings about any current concerns, such as marital problems or financial difficulties, as well as concerns they might raise about their infant.	Usual Care. Participants were case-managed by their maternal and child health nurse and referred to other agencies/services as necessary, as normally happens where specialized programs are unavailable.	10 weeks	NR	NR	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of Counseling	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Segre, 2015, 25486371	Individual listening visits, delivered by bachelors- or doctoral-level interventionists. Session involved active and reflective listening, and problem solving. Visits were conducted in a location convenient for the participant	Waitlist control	6	30 -50 min	Weekly	Prenatal and postnatal

Abbreviations: TAU = treatment as usual, NR = not reported

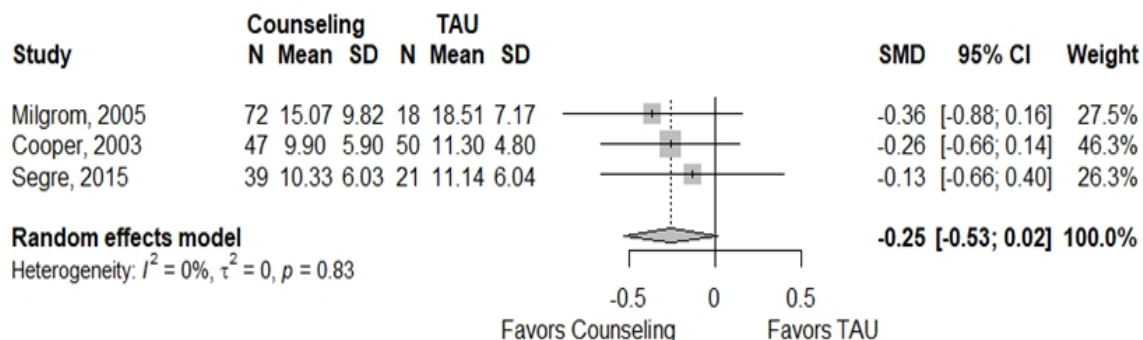
3.3.2.6.1 Risk of Bias

Specific concerns were related to the blinding of participants and personnel (two high and one unclear risk of bias) and allocation concealment (two unclear and one low risk of bias). All other domains were rated low risk of bias.

3.3.2.6.2 Depressive Symptoms

Three studies included measures of depressive symptoms at the end of treatment in 247 participants. Meta-analysis (Figure 16) provided insufficient evidence that depressive symptoms at the end of treatment significantly differed between participants who received counseling compared with those who received TAU (summary SMD -0.25 , 95% CI -0.53 to 0.02 , I^2 0%). Effect sizes were consistent but imprecise.

Figure 16. Counseling versus TAU for depressive disorders: Depressive symptoms at the end of treatment



Abbreviations: TAU = treatment as usual, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval.

3.3.2.6.3 Remission Rate of Depressive Symptoms

One study (Cooper 2003) reported on the proportion of participants whose symptoms of depression, as rated by a validated scale, remitted at the end of treatment (Appendix Table F-31). There was no difference in the proportion of participants who reached remission between the counseling and treatment groups (RR 1.35, 95% CI 0.88 to 2.08).

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.6.4 Clinically Meaningful Difference in Depressive Symptoms

One study (Segre 2015) reported on the proportion of participants who experienced a clinically meaningful improvement in their symptoms of depression measured by different validated scales (Appendix Table F-32). Segre 2015 calculated reliable change indices as a measure of clinical significance. A reliable change index is a ratio which represents whether a participants change in scores between timepoints is considered statistically significant. The numerator is the observed difference in scores and the denominator is the standard error of the measurement of the difference. More participants in the counseling group experienced a clinically meaningful improvement in on the Inventory of Depression and Anxiety Symptoms General Depression Subscale (IDAS-GD) (RR 2.42, 95% CI 1.19 to 4.92). Similar effects were not found with more rigorous measures of depression including the HAM-D (RR 2.51, 95% CI 0.81 to 7.77) or the EPDS (RR 1.50, 95% CI 0.87 to 2.58).

3.3.2.6.5 Anxiety Symptoms

One study (Milgrom 2005) reported on the anxiety symptoms of participants, using a validated scale (BAI) at the end of the intervention (Appendix Table F-33). There was no difference in symptoms of anxiety at the end of treatment between the counseling and TAU groups (SMD -0.4, 95% CI -0.93 to 0.11).

3.3.2.6.6 Quality of Life

One study (Segre 2015) assessed quality of life using the Quality of Life, Enjoyment, and Satisfaction Questionnaire (Q-LES-Q), which asked participants to rate how they feel they are getting along at work, at home, with other people, and how satisfied they are with life overall. There was no difference in quality-of-life scores between the counseling and TAU groups (SMD 0.09, 95% CI -0.45 to 0.62) (Appendix Table F-34).

3.3.2.6.7 Social Functioning

One study (Segre 2015) reported on the mother's social functioning using the WSAS, where a higher score indicates more impaired social functioning. Social functioning scores were higher in the counseling group compared with TAU (SMD -0.70, 95% CI -1.30 to -0.20) (Appendix Table F-35).

3.3.2.6.8 Parent-Infant Bonding

One study (Cooper 2003) reported on the proportion of participants who experienced parent-infant relationship problems using maternal self-reports and proportion of participants with a secure attachment (as ascertained through Ainsworth's strange situation) (Appendix Table F-37). However, the study was small and provided only a highly imprecise estimate of no difference in the proportion of participants reporting bonding problems (RR 0.87, 95% CI 0.64 to 1.19). Similar proportions of participants in the counseling and TAU groups had a secure attachment type (counseling 41.0% and TAU 43.0%), however the number of participants with secure attachment types was not reported.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.6.9 Child Emotional and Behavioral Difficulties

One study (Cooper 2003 [reported in Murray 2003]¹⁷⁸) measured child emotional and behavioral difficulties (Appendix Table F-37). They assessed behavioral and emotional difficulties on the BSQ, which captured maternal reports of behavioral issues at 72 weeks (18 months) postpartum, the Rutter A² scale, which captured parental reports of behavioral difficulties at 5 years postpartum; the PBCL, which captured teacher reports of behavioral difficulties five years postpartum. On all three measures, a higher score indicates greater behavioral difficulties.

At 18 months, children of participants in the counseling and TAU groups had similar scores on the BSQ at 18 months postpartum (Median 4 [Range 0 to 11] vs. Median 6 [Range 1 to 15]), with a median difference of 2.

At 5 years, children whose mothers had received counseling reported similar scores on the Rutter A² compared with children of mothers the TAU group (11 [1 to 28] vs. median 9 [range 3 to 33]), with a median difference of 3 (range not reported). The authors reported this difference was not statistically significant ($P = 0.07$). Similarly, there was no differences in behavioral difficulties as measured by the PBCL between the CBT and counseling groups (Median 3 [range 0 to 24] vs. 3 [range 0 to 14]), with median difference of 0 (range not reported) ($P = 0.99$).

3.3.2.6.10 Infant and Child Cognitive Development

One study (Cooper 2003 [reported in Murray 2003]¹⁷⁸) included measures of infant and child cognitive development (Appendix Table F-38). They measured infant cognitive development by using the Mental Development Index of the Bayley scales for Infant Development at 72 weeks (or 18 months). The Bayley scales are norm-referenced, where infants are rated against the performance of their peers. Infants with significantly lower scores than their peers may be developmentally delayed. Children of participants in the counseling group reported similar scores on the Mental Development Index compared with TAU (counseling median 114 [range 64 to 150] vs. TAU median 116 [85 to 150]), with a median difference of 2. The authors reported there was no statistical difference scores between the CBT and counseling groups ($P = 0.85$).

The same study also measured child cognitive development at 5 years using the General Cognitive Index of the McCarthy Scale. Scores on the Global Cognitive Index are standardized, with a mean of 100 and standard deviation of 16. Children of participants in both groups had median scores above average (Counseling median 107 range [54 to 148] vs. TAU median 108 [50 to 140]), with a median difference of 4. The authors reported there was no statistical difference in scores on the Global Cognitive Index between the groups ($P = 0.91$).

3.3.2.7 Exercise Versus TAU

Six studies compared exercise to treatment as usual among 516 participants with depressive disorders (Table 13). Four studies tested individualized exercise programs, which were delivered to participants via consultations with exercise professionals at the start of treatment (Da Costa 2009, Daley 2008, Daley 2015, and Forsyth 2017). Three of which also provided support or followup consultations during the intervention period. Three studies tested supervised group exercise programs. One study tested a group exercise class consisting of cardio exercises, strength exercises and stretching (Broberg 2021) and one study tested a moderate intensity walking group (Armstrong 2003). All six studies compared exercise to treatment as usual. All

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

studies included participants during the postnatal period, with the exception of Broberg 2021 who included prenatal and postnatal participants.

Outcomes included: depressive symptoms, remission rate of depressive symptoms, anxiety symptoms health-related quality-of-life, perceived availability of social support, adherence to treatment.

Table 13. Exercise versus TAU for depressive disorders: Description of interventions and comparisons

Study, Year, PMID	Description of Exercise	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Armstrong, 2003, 12956024 ⁷⁷	Walking three times per week with the group for 30–40 minutes at a moderated intensity (60–75% of age predicted heart rate). Participants were invited to attend weekly informal social gathering after walking sessions and complete exercise diaries.	Usual care. Additional phone support was provided to participants at week 6	36	30 min	3 times per week	Postnatal
Broberg, 2021, 32862425 ⁸⁰	Supervised group exercise consisting of: 10-minute warm-up, 20 minutes of endurance training on treadmills, exercise bikes or cross trainers, 25 minutes of strength training (back, abdomen, thighs, arms and pelvic floor) and 15 minutes of stretching and relaxation	Usual care. Participants received frequent prenatal visits with specialized midwives and obstetricians experienced with mental health disorders. These visits include general guidance on physical exercise for pregnant women.	24	70 min	Twice weekly	Prenatal and postnatal
Da Costa, 2009, 19728220 ⁸⁷	Individualized exercise prescription. Participants were recommended to perform 60–120 min/week of aerobic exercise within their target heart rate zone (60–85% of maximal heart rate).	Usual care.	4 Exercise group sessions	1 90 min session; 4 30min sessions	Baseline, weeks 1, 3, and 9.	Postnatal
Daley, 2008, 18399022 ⁸⁸	One-to-one exercise consultations encouraging participants to increase physical activity.	Usual care. Participants were asked not to change their exercise routines.	2	60 min	Week 1 and week 4	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of Exercise	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Daley, 2015, 25804297 ⁸⁹	Weeks 1-12 complete 30 min of moderate-intensity exercise 3 days per week. Weeks 13-24 aim complete 30 min of moderate-intensity exercise on 3-5 days per week.	Usual care from GP and an educational leaflet encouraging self-care.	Two face-to-face personalized exercise consultations (during months 1 and 2) and telephone calls (during months 3 and 4).	Consultations 40-60 min. Telephone calls 15-20 min.	Monthly	Postnatal
Forsyth, 2017, 28278021 ⁹⁶	A face-to-face 60-minute consultation to motivate them (using a behavior change approach) to undertake 150 minutes/week of moderate-intensity exercise.	Usual care	1	60 min	One-off	Postnatal

Abbreviations: GP = general practitioner, TAU = Treatment as Usual

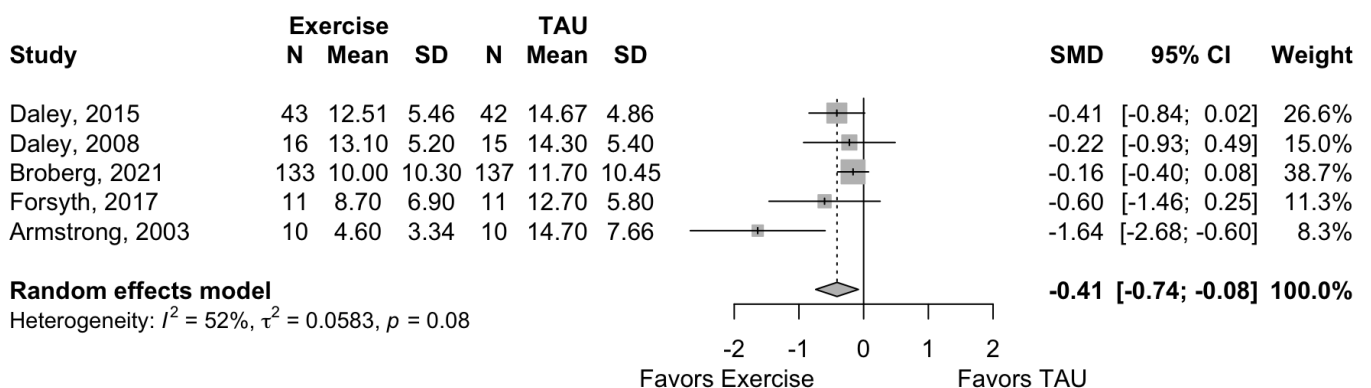
3.3.2.7.1 Risk of Bias

The most common concerns were related to the blinding of participants (6/6 studies high risk of bias), intention-treat analysis (2/6 studies high risk of bias and 1/7 studies unclear risk of bias). All other domains were rated low risk of bias.

3.3.2.7.2 Depressive Symptoms

Five studies included measures depressive symptoms (using the EPDS or HAM-D) at the end of treatment in 428 participants. Meta-analysis (Figure 17) suggests that those randomized to an exercise intervention had a significant reduction in depressive symptoms compared with those who received TAU (summary SMD -0.41 , 95% CI -0.74 to -0.08 , I^2 52%).

Figure 17. Exercise versus TAU for depressive disorders: Depressive symptoms at the end of treatment



3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Abbreviations: TAU = treatment as usual, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval.

3.3.2.7.3 Remission Rate of Depressive Symptoms

One study (Broberg 2021) evaluated the remission rate of depressive symptoms (defined as an EPDS score than or equal to 11) at 29 to 34 gestational weeks (which was the end of treatment) and again at 8 weeks postpartum. There was no difference in remission rates at 29 to 34 gestational weeks (RR 0.77, 95% CI 0.51 to 1.16), however a greater proportion of participants in the TAU group reach remission at 8 weeks postpartum (RR 0.44, 95% CI 0.28 to 0.69) (Appendix Table F-39).

3.3.2.7.4 Anxiety

One study (Broberg 2021) assessed anxiety levels using the STAI. The median difference in anxiety scores was -1.3) at 8 weeks and 0.04 at 29 to 34 weeks. Variance data were not reported; thus, it was not possible to calculate the SMD for these outcomes (Appendix Table F-40).

3.3.2.7.5 Health Related Quality of Life

One study (Daley 2015) reported measures of health-related quality of life. The study found no significant differences in quality-of-life scores assessed by the EQ-5D, Mental Health Component of the Short Form-12 Component (SF-12), or Physical Health Component of the SF-12 (Appendix Table F-41).

3.3.2.7.6 Perceived Availability of Social Support

One study (Armstrong 2003) assessed perceived availability of social support using the Social Support Interview (SSI). No significant differences were observed between exercise and TAU after 12 weeks (SMD 0.66, 95% CI -0.25 to 1.56) (Appendix Table F-42).

3.3.2.7.7 Adherence to Treatment

One study (Da Costa 2009) measured participants' adherence to the exercise program by asking them to report how many minutes of aerobic exercise they were completing per week. Participants in the exercise group reported engaging in more minutes of aerobic exercise per week compared with participants in the TAU group with a mean difference of 69.4 minutes (SMD 0.86, 95% CI 0.43 to 1.30) (Appendix Table F-43).

3.3.2.8 IPT Versus TAU

Nine studies compared IPT to TAU in 1,003 participants (Table 14). Most studies (6/9) tested an individual IPT intervention, two studies tested a group IPT intervention, and one study tested a self-guided online IPT intervention. All group and individual IPT interventions were delivered by mental-health professionals. Half of the studies compared IPT to enhanced TAU, where depressive symptoms were actively monitored by the research team and those with high levels of depressive symptoms were referred to or encouraged to engage with locally available services and treatments for depression, the remaining compared IPT to usual care (3/9) and a waitlist control (1/9). The number of IPT sessions ranged between 8 and 14. Four studies had at least one pre-IPT engagement session and two studies included maintenance IPT, after the initial IPT treatment had been completed. Studies varied in how frequently IPT was provided, with many

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

not reporting the frequency of IPT sessions, however most studies tested weekly or biweekly IPT sessions. Six studies included participants in the postnatal period and three studies included participants in the prenatal period.

Outcomes included: anxiety symptoms, depressive symptoms, parent-infant bonding, social functioning, availability of social support, adherence to treatment, and remission rate of anxiety and depressive symptoms.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Table 14. IPT versus TAU for depressive disorders: Description of interventions and comparisons

Study, Year, PMID	Description of IPT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Dennis, 2020, 32029010 ⁹¹	Nurse-led individual IPT via telephone. Intervention identified problem area(s) related to current depressive episode, focused on resolving interpersonal issues and developed contingency plans for future depressive episodes	Usual care	12	60 min	Weekly	Postnatal
Grote, 2009, 19252043 ⁹⁹	Individual, culturally enhanced IPT, in-person or via telephone. Delivered by a masters- or doctoral-level clinician. Participants received an engagement session before IPT, based on motivational interviewing. Participants received eight sessions of IPT, followed by postpartum maintenance sessions. IPT was focused on resolving one of four interpersonal problem areas: role transition, role dispute, grief and interpersonal deficits	Enhanced treatment as usual. Participants were given written educational materials and research staff contacted participants every 3 weeks to assess their mood and encourage them to enter treatment, if needed.	1 engagement session, 8 sessions of IPT, up to 6 maintenance sessions	NR	Biweekly or monthly	Prenatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of IPT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Hankin, 2023, 37074698 ¹⁴¹	Individual IPT delivered by a mental health professional. Intervention included: psychoeducation, interpersonal skill building, access to community services, and access to antidepressant medication if necessary.	Enhanced usual care. Participants were referred to locally available services based on their preferences.	8	50 min	Biweekly	Prenatal
Lenze, 2017, 28038377 ¹⁰³	Individual IPT delivered by clinical psychologists and conducted in a location convenient to the participant. The IPT treatment was based on the model developed by Grote 2009, 19252043 ⁹⁹	Enhanced treatment as usual. Participants were monitored for depressive symptoms every two weeks by research staff. Participants with high levels of depressive symptoms were encouraged to enter or continue with treatment.	1 engagement session, 8 sessions of IPT, maintenance sessions available	NR	NR	Prenatal
Mennen, 2021, 33221606 ¹³⁷	Group IPT delivered by a mental health professional. Intervention included: cohesion building, and introduction IPT problem areas, role transitions, interpersonal disputes, grief and loss.	Enhanced usual care. Participants with clinical levels of depression were referred to locally available mental health services.	2 individual engagement sessions, 12 group sessions	60 min	Weekly or biweekly	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of IPT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Mulcahy, 2010, 19697094 ¹¹⁴	Group IPT delivered by a trained therapist. Addressed social role transitions, conflicts and issues with key relationships, as well as grief and loss issues associated with becoming a parent	Usual care with access to locally available treatments including: medication, natural remedies, non-directive counseling, Maternal and Child Health Nurse support, community support groups, and individual psychotherapy or group therapy already provided in the community.	2 individual sessions, 8 group IPT sessions, and a 2-hour partner session	120 min (group sessions)	NR	Postnatal
O'Hara, 2000, 11074869 ¹¹⁷	Individual IPT delivered by counseling or clinical psychologists. Identifying IPT problem area(s) and setting treatment goals. Problem areas included: interpersonal disputes, role transition, as well as grief and loss issues associated with becoming a parent. Contingency plans for managing future depressive episodes were discussed	Waitlist control	12	60 min	Weekly	Postnatal
Toth, 2013, 24229549 ¹²⁶	Individual IPT delivered by masters- or doctoral-level therapists, either at home or in the clinic depending on the participant's preference.	Enhanced usual care. Participants were referred to locally available services.	14	60 min	Weekly	Postnatal

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Study, Year, PMID	Description of IPT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Vigod, 2021, 33949762 ¹³²	Online, self-guided IPT with optional weekly live chats. Intervention included: (1) psychoeducation around the common types of postpartum mental illness, etiology, and treatment options, (2) issues related to obtaining adequate social support, and (3) interpersonal problem areas, including challenges related to baby's sleep and feeding, maternal identity, and interpersonal relationships with partners.	Usual care	10	N/A - self-guided	Weekly	Postnatal

Abbreviations: IPT = interpersonal therapy, TAU = treatment as usual, NR = not reported, N/A = not applicable.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.8.1 Risk of Bias

Specific concerns were related to the blinding of participants and personnel (6/9 high and 3/9 unclear risk of bias), allocation concealment (4/9 unclear and 5/9 low risk of bias), and blinding of outcome assessors (3/9 high, 4/9 unclear, and 2/9 low risk of bias). All other domains were rated low risk of bias.

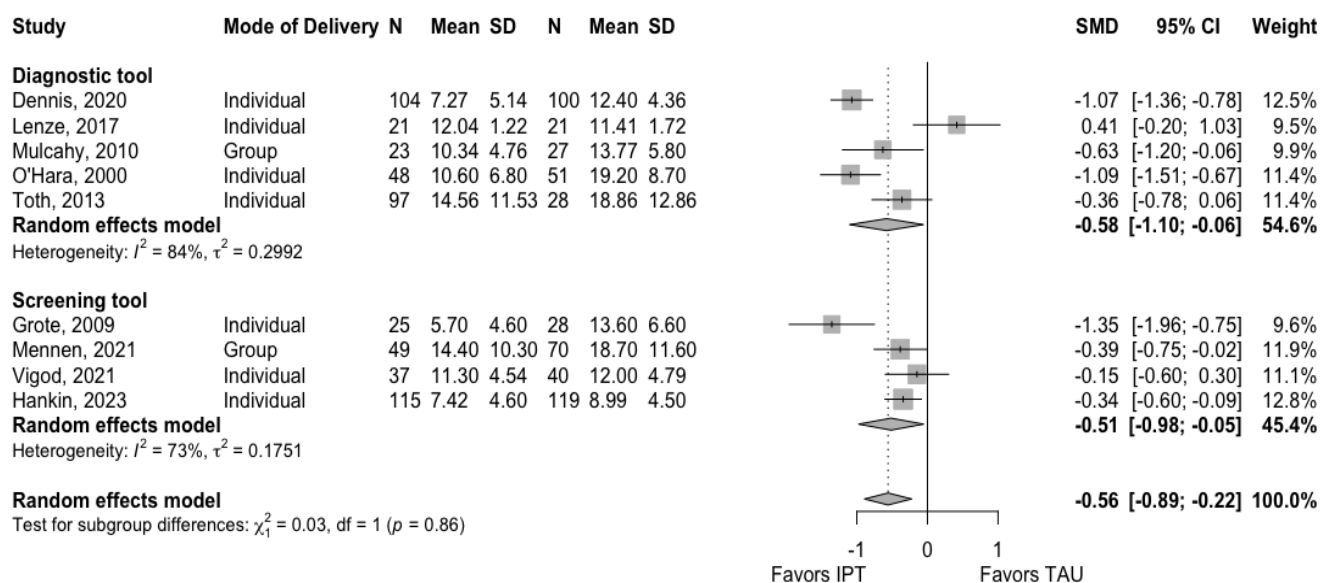
3.3.2.8.2 Depressive Symptoms

Nine studies reported measures of depressive symptoms at the end of treatment from 1003 participants.

Studies used differing eligibility criteria to confirm a depression diagnosis at enrollment. Five studies used a structured diagnostic tool based on clinical criteria (i.e. the SCID) and three studies used a screening tool (e.g. the EPDS or BDI). Across tools used to confirm a depression diagnosis, meta-analysis (Figure 18) provided evidence that depressive symptoms at the end of treatment decreased significantly between participants who received interpersonal psychotherapy and those who received treatment as usual (summary SMD -0.56 , 95% CI -0.89 to -0.22).

Overall, there was a large degree of statistical heterogeneity (regarding the magnitude of effect), but with the exception of the smallest study (Lenze 2017), studies consistently favored IPT over TAU, mostly with statistically significant differences.

Figure 18. IPT versus TAU for depressive disorders: Depressive symptoms at the end of treatment



Notes. Self-guided mode of delivery includes individual and group intervention.

Abbreviations. CI = confidence intervals, IPT = Interpersonal therapy, SD = standard deviation, SMD = standardized mean difference, TAU = treatment as usual.

3.3.2.8.2.1 Diagnostic Criteria and Depressive Symptoms

We examined whether there were any differences in depressive symptoms at the end of treatment between studies using diagnostic or screening tools to assess depressive symptoms at enrollment. Depressive symptoms were lower in participants who received IPT and were

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

assessed with a diagnostic tool at enrollment (summary SMD -0.58, 95% CI -1.10 to -0.06) or a screening tool (summary SMD -0.51, 95% CI -0.98 to -0.05) compared with TAU. This difference was not statistically significant, based on meta-regression ($P = 0.85$).

3.3.2.8.2.2 Delivery Mode Subgroup Analysis

We compared studies that used delivered IPT in a group setting or individually. Due to the low number of studies, we combined therapist led and self-guided individual CBT. The subgroup meta-analyses are summarized in Table 15. Based on meta-regression, there were no significant differences in the SMD of depressive symptoms at the end of treatment across the different modes of delivery ($P = 0.86$).

Table 15. IPT versus TAU for depressive disorders: Depressive symptoms by IPT delivery mode

Delivery Mode	K	SMD (95% CI)
Group	2	-0.45 (-0.76, -0.14)
Individual (therapist led or self-guided)	7	-0.57 (-1.02, -0.13)

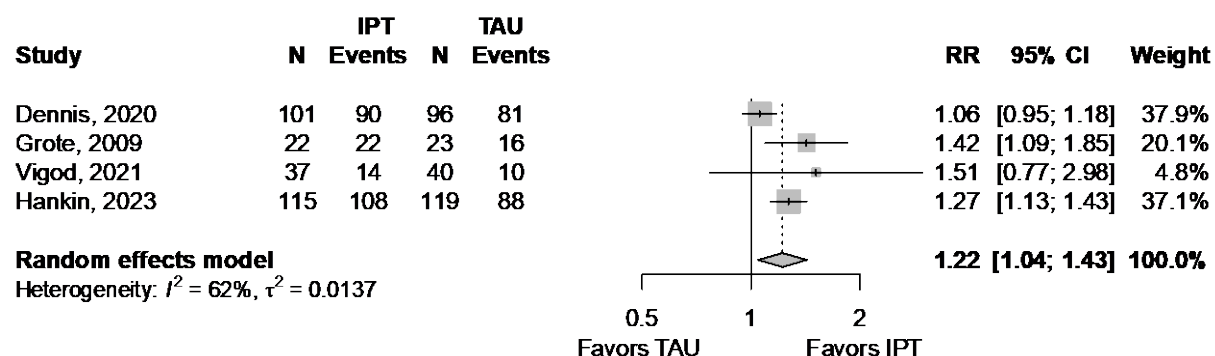
Note: all differences are statistically significant.

Abbreviations: IPT = interpersonal therapy, TAU = treatment as usual, K = number of studies, SMD = standardized mean difference, CI = confidence interval.

3.3.2.8.3 Remission Rate of Depressive Symptoms

Four studies reported on the proportion of participants whose symptoms of depression reached remission at the end of treatment or at followup. Remission of depressive symptoms was defined as scoring below a predefined cutoff on a validated depression scale or not meeting the criteria of major depression. Meta-analysis (Figure 19) provided evidence that remission rate of depressive symptoms at the end of treatment or at the study followup were significantly higher in the IPT group (summary RR 1.22, 95% CI 1.04 to 1.42, I^2 62%). Studies were inconsistent, with two studies (Grote 2009 and Vigod 2021) showing no difference between IPT and TAU. The summary SMD was precise, but there was moderate heterogeneity.

Figure 19. IPT versus TAU for depressive disorders: Remission of depressive symptoms at the end of treatment or followup



Abbreviations: CI = confidence interval, IPT = Interpersonal therapy, TAU = treatment as usual, RR = relative risk.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

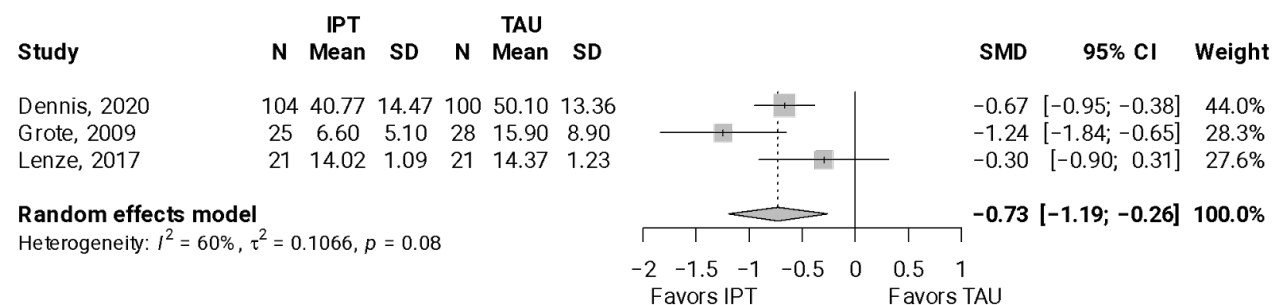
3.3.2.8.4 Response Rate of Depressive Symptoms

One study (Grote 2009) reported on the proportion of participants whose symptoms of depression, as rated by a validated scale, improved by 50 percent at the end of treatment (Appendix Table F-44). The study reported that a greater proportion of participants in the IPT group experienced a 50 percent improvement in depression scores on the EPDS (RR 2.80, 95% CI 1.51 to 5.19).

3.3.2.8.5 Anxiety Symptoms

Three studies reported measures of anxiety symptoms at the end of treatment for 299 participants. Meta-analysis (Figure 20) provided evidence that anxiety symptoms at the end of treatment significantly decreased between participants who received interpersonal psychotherapy and those who received treatment as usual (summary SMD -0.73 , 95% CI -1.19 to -0.26 , I^2 60%).

Figure 20. IPT versus TAU for depressive disorders: Anxiety symptoms at the end of treatment



Abbreviations: CI = confidence interval, IPT = Interpersonal therapy, SD = standard deviation, SMD = standardized mean difference, TAU = treatment as usual.

3.3.2.8.6 Remission Rate of Anxiety Symptoms

One study (Dennis 2020) reported on the proportion of participants whose symptoms of anxiety reached remission at the end of treatment. Remission of depressive symptoms was defined as a score below 44 on the STAI. A greater proportion of participants in the IPT group reach remission for anxiety symptoms (RR 1.70, 95% CI 1.25 to 2.32) (Appendix Table F-45).

3.3.2.8.7 Remission Rate of Depressive and Anxiety Symptoms

One study (Dennis 2020) reported on the proportion of participants whose symptoms of depression and anxiety reached remission at the end of treatment (Appendix Table F-46). Remission was defined as scoring below 12 on the EPDS and scoring below 44 on the STAI. A greater proportion of participants in the IPT group reached remission for depressive and anxiety symptoms (RR 1.50, 95% CI 1.23 to 1.83).

3.3.2.8.8 Adherence to Treatment

Two studies (Grote 2009 and Lenze 2017) reported on adherence to treatment. Lenze 2017 reported that 71.4% of participants in the IPT group completed at least 4 sessions. Grote reported a greater proportion of participants in the IPT group completed all sessions compared with TAU (RR 9.52, 95% CI 2.44 to 37.18).

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

3.3.2.8.9 Parent-Infant Bonding

Two studies assessed parent-infant bonding at the end of treatment or at 8-month followup. One study (Mulchay 2010) assessed mother-infant relationship by Maternal Attachment Inventory (MAI) scale, self-reported affectional caregiving from the mother to the infant at the end of treatment (Appendix Table F-48). Participants in the IPT group reported being more likely to experience higher perceptions of the mother-infant relationship compared with participants in the TAU group (SMD 0.58, 95% CI 0.01 to 1.15). The other study (Toth 2013) reported no differences in disorganized attachment characteristics scores between the IPT and TAU groups (SMD -0.10, 95% CI -0.52 to 0.32).

3.3.2.8.10 Perceived Self-Efficacy for Parenthood

One study (Toth 2013) measured the mother's feelings of self-efficacy related to specific demands of parenting role by using the Maternal Efficacy Questionnaire (MEQ) at 8-month followup (Appendix Table F-49). There was no difference in perceived self-efficacy for parenthood scores at the end of treatment between the IPT and TAU groups (SMD -0.16, 95% CI -0.58 to 0.26).

3.3.2.8.11 Social Functioning

One study (Grote 2009) assessed social functioning of participants by Social and Leisure Domain of the Social Adjustment Scale (SAS) at the end of treatment (Appendix Table F-50). Participants in the IPT group reported an improvement in social functioning compared with the TAU group (SMD -0.95, 95% CI -1.52 to -0.38).

3.3.2.8.12 Social Support

Two studies (Lenze 2017 and Mulchay 2010) measured social support of participants by using the Social Support Questionnaire Revised (SSQR) scale or Interpersonal Support Evaluation List (ISEL) at the end of treatment (Appendix Table F-51). Lenze 2017 found much higher levels of social support among the IPT group (SMD 2.09, 95% CI 1.33 to 2.85), however a similar effect was not found by Mulchay 2010 (SMD 0.30, 95% CI -0.26 to 0.86).

3.3.2.8.13 Toddler Temperament

One study (Toth 2013) measured the toddler's temperament and activity levels at 8-month followup (Appendix Table F-52). There were no significant differences in toddler anger scores (SMD -0.06, 95% CI -0.05 to 0.47) or toddler activity levels (SMD -0.09, 95% CI -0.51, 0.33) between the IPT and TAU groups.

3.3.2.9 Summary of Studies Included in the Evidence Map

We identified 30 RCTs^{144-150, 152-159, 161-174, 176} testing nonpharmacologic treatments for depressive disorder, which are summarized in Appendix Table C-1. Five studies tested IPT interventions. One compared IPT with CBT (Evans 2021), one IPT with massage with IPT (Field 2009), one IPT with peer support (Field 2013), one IPT with psychoeducation (Johnson 2016), and one standard IPT with clinician-managed IPT (Stuart 2023). All five studies reported positive findings for the effectiveness of IPT, and clinician-managed IPT was more efficient in treating depression compared to standard IPT.

3.3.2 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive Disorders

Three studies tested yoga interventions. Buttner compared yoga with TAU, Field 2013 with a peer support group, and Mitchell 2012 with psychoeducation. Mitchell 2012 and Buttner 2015 reported yoga was more effective in treating depressive symptoms, however similar effects were not reported by Field 2013.

Two studies (Kim 2019 and Vigod 2019) compared transcranial magnetic stimulation (TMS) with sham TMS, however only Vigod 2019 reported a significant difference in depressive symptoms between the groups.

Psychoeducation and clinical monitoring was more effective than TAU (Rojas 2007), acupuncture was more effective than progressive muscle relaxation or TAU (Ormsby 2020), online songwriting intervention was more effective than TAU (Perkins 2023), and Resilience Enhancement Skills Training (REST) was more effective than video conferencing technology (VCT)-based problem-solving individual therapy (Cluxton-Keller 2023). There were no significant differences between a singing group and play-group or TAU (Fancourt 2018), doula support and TAU (Gjerdingen 2013), peer support and TAU (Letourneau 2011), problem-solving therapy and TAU (Van Horne 2022), Trauma-focused CBT or TAU (Horwitz 2015).

Three RCTs tested nonpharmacologic interventions on participants with a mix of different mental health conditions (Pan 2023, Challacombe 2024 and Richter 2012). One RCT testing mindfulness for depressive, anxiety and/or stress disorders reported that mindfulness was more effective than control group in reducing prenatal and postnatal stress, anxiety, and depression, however, there was no significant difference in the quality of mother-infant bonding (Pan 2023). One RCT (Challacombe 2024) reported that time intensive delivery of CBT was more effective than standard weekly-one hour CBT in a study of participants with a combination of anxiety-related disorders (PTSD, OCD, panic disorder, or social anxiety disorder). Richter 2012 found CBT combined with psychoeducation was associated with significantly lower cortisol levels at the end of treatment for participants with anxiety, depression, or stress.

3.3.3 KQ 1: Nonpharmacologic Treatments for Anxiety Disorders

We identified two studies testing nonpharmacologic treatments for perinatal individuals with anxiety disorder. O'Mahen 2022 compared a multicomponent intervention with TAU and Okatsau 2023 compared CBT with TAU. The SoE of nonpharmacologic interventions for anxiety disorder is summarized in Table 16.

3.3.3 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, Key Question 1: Nonpharmacologic Treatments for Anxiety Disorders

Table 16. KQ 1: Strength of evidence of nonpharmacologic treatments for anxiety disorder

Type of Outcome	Outcome ^a	Comparison	N Studies (Participants)	RoB	Consistency	Precision	Directness	Overall SoE	Conclusions
Scores of psychological assessments	Anxiety	MULTI vs TAU	1 (96)	Low	N/A	N/A	Direct	Insufficient	No conclusions
	Anxiety	CBT vs TAU	1 (61)	High	N/A	N/A	Direct	Insufficient	No conclusions
	Depression	MULTI vs TAU	1 (96)	Low	N/A	N/A	Direct	Insufficient	No conclusions
	Depression	CBT vs TAU	1 (61)	High	N/A	N/A	Direct	Insufficient	No conclusions
	Parental Anxiety	MULTI vs TAU	1 (96)	Low	N/A	N/A	Direct	Insufficient	No conclusions
	Quality of life	MULTI vs TAU	1 (96)	Low	N/A	N/A	Direct	Insufficient	No conclusions

^aComparisons with three or fewer studies in total are omitted

Abbreviations: KQ = Key Question, SoE = strength of evidence, CBT = cognitive behavioral therapy, MULTI= multi-component intervention (consisting of problem-solving therapy, self-care, and psychoeducation, TAU = treatment as usual, N/A = not applicable, RoB = risk of bias

3.3.3 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, Key Question 1: Nonpharmacologic Treatments for Depressive and Anxiety Disorders

3.3.3.1 Multicomponent Intervention Versus TAU

One RCT (O'Mahen 2022)¹³⁸ compared a multicomponent group intervention (consisting of problem-solving therapy, self-care and psychoeducation) delivered by mental health professionals with TAU (Table 17). The intervention consisted of three 90-minute sessions, which were scheduled every three weeks. Participants were in the prenatal period.

Outcomes included: anxiety symptoms, depressive symptoms, pregnancy related anxiety symptoms, and quality of life.

Table 17. Multicomponent intervention versus TAU for anxiety disorders: Description of interventions and comparisons

Study, Year, PMID	Description of Multicomponent Intervention	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
O'Mahen, 2022, 35177019 ¹³⁸	Manualized group intervention delivered by a midwife and trainee clinical psychologist. Primary strategies included problem-solving therapy, managing uncertainty, and self-care.	Usual care. Participants were able to access locally available services.	3	90 minutes	Every three weeks	Prenatal

Abbreviations: TAU = treatment as usual.

3.3.3.1.1 Risk of Bias

O'Mahen 2022 was rated high risk of bias for blinding of participants and personnel and unclear risk of bias for blinding of outcome assessors. All other domains (random sequence generation, allocation concealment, incomplete outcome data, selective reporting, and intention-to-treat analysis) were rated low risk of bias.

3.3.3.1.2 Anxiety Symptoms

O'Mahen 2022 compared anxiety symptoms at the end of treatment using the GAD-7 (Appendix Table F-53). Anxiety symptoms were similar at the end of treatment between intervention groups (SMD -0.27, 95% CI -0.68 to 0.13).

3.3.3.1.3 Depressive Symptoms

O'Mahen 2022 compared depressive symptoms at the end of treatment using the EPDS (Appendix Table F-53). There was no difference in depressive symptoms at the end of treatment between groups (SMD -0.03, 95% CI -0.43 to 0.37).

3.3.3.1.4 Pregnancy Related Anxiety

O'Mahen 2022 compared pregnancy-related anxiety symptoms at the end of treatment using the Pregnancy-Related Anxiety Scale (PRAQ) (Appendix Table F-53). The PRAQ identifies fears and worries specific to the current pregnancy, including fear of child birth and higher scores indicate greater levels of anxiety. Pregnancy related anxiety scores were lower in the

3.3.3 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, Key Question 1: Nonpharmacologic Treatments for Depressive and Anxiety Disorders

multicomponent intervention group compared with TAU (SMD -0.40 , 95% CI -0.81 to -0.01); however, this effect size nears statistical insignificance and may not represent a clinically meaningful difference.

3.3.3.1.5 Quality of Life

O’Mahen 2022 compared participants quality of life at the end of treatment using the EQ-5D, where a higher score indicates better quality of life (Appendix Table F-53). There was no difference in quality of life scores at the end of treatment between groups (SMD 0.17 , 95% CI -0.23 to 0.57)

3.3.3.2 CBT Versus TAU

One RCT (Okatsau 2023)¹⁴⁰ compared CBT with TAU (Table 18). The intervention consisted of three 30-minute sessions individual sessions, which were delivered via video-conferencing software by a CBT therapist. The sessions were scheduled at times that suited the participant. Participants were in the prenatal period.

Outcomes included: anxiety symptoms and depressive symptoms.

Table 18. CBT versus TAU for anxiety disorders: Description of interventions and comparisons

Study, Year, PMID	Description of Multicomponent Intervention	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Okatsau, 2023, 37163508 ¹⁴⁰	Individual CBT delivered remotely via Zoom by a CBT therapist. Intervention included introduction to CBT, developing an image of postpartum life, and CBT work to cope with postpartum life. Participants were taught cognitive and behavioral techniques.	Usual care.	3	30 minutes	NR	Prenatal

Abbreviations: CBT = cognitive behavioral therapy, NR = not reported, TAU = treatment as usual

3.3.3.2.1 Risk of Bias

Okatsau 2023 was rated high risk for numerous domains, including blinding of participants and personnel, blinding of outcome assessors, selective reporting, and intention-to-treat analysis. All other domains (random sequence generation, allocation concealment, and incomplete outcome data) were rated low risk of bias.

3.3.3.2.2 Anxiety Symptoms

Okatsau compared anxiety symptoms at the end of treatment using the GAD-7 (Appendix Table F-54). Anxiety symptoms were similar at the end of treatment between intervention groups (SMD -0.17 , 95% CI -0.68 to 0.33).

3.3.3 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, Key Question 1: Nonpharmacologic Treatments for Depressive and Anxiety Disorders

3.3.3.2.3 Depressive Symptoms

Okatsau 2023 compared depressive symptoms at one month postpartum using the EPDS in 61 participants (Appendix Table F-54). The results were presented as median differences with quartile deviations. It was not possible to estimate means and standard deviations from the published data. The study authors report that the median EPDS scores at 1 month postpartum was 4.0 (interquartile range [IQR] 3.22) for the CBT group and 4.5 (IQR 3.50) for the TAU group. A Mann-Whitney-U test determined there was no significant difference between groups ($P = 0.95$).

3.3.4 KQ 1: Nonpharmacologic Treatments for Depressive and Anxiety Disorders

We identified four studies testing nonpharmacologic treatments for participants who were diagnosed with both depressive and anxiety disorders. One study (Field 2013) compared exercise with TAU and three studies compared CBT with TAU. Table 19 summarizes the SoE for prioritized outcomes.

3.3.4 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, Key Question 1: Nonpharmacologic Treatments for Depressive and Anxiety Disorders

Table 19. KQ 1: Strength of evidence of nonpharmacologic treatments for depressive and anxiety disorders

Type of Outcome	Outcome ^a	Comparison	N Studies (Participants)	RoB	Consistency	Precision	Directness	Overall SoE	Conclusions
Scores on psychological assessments	Depression	CBT vs TAU	3 (269)	Moderate	Inconsistent	Imprecise	Direct	Low	CBT more effective
	Depression	Yoga vs TAU	1 (75)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions
	Anxiety	CBT vs TAU	3 (269)	Moderate	Consistent	Imprecise	Direct	Low	CBT more effective
	Anxiety	Yoga vs TAU	1 (75)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions

^aComparisons with three or fewer studies in total are omitted

Abbreviations: KQ = Key Question, CBT = cognitive behavioral therapy, EXE = exercise, N/A = not applicable, RoB = risk of bias, SoE = strength of evidence, TAU = treatment as usual

3.3.4 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive and Anxiety Disorders

3.3.4.1 Yoga and Tai Chi Versus TAU

One study (Field 2013) compared combined yoga and tai chi with TAU among participants with both depression and anxiety. Field 2013 compared a weekly 20-minute exercise class, combining elements of yoga and tai chi, with a waitlist control group (Table 20). Participants were in the prenatal period.

Outcomes include depressive and anxiety symptoms.

Table 20. Yoga and tai chi versus TAU for depressive and anxiety disorders: Description of interventions and comparisons

Study, Year, PMID	Description of Exercise	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Field, 2013, 23337557 ⁹⁴	Yoga and tai chi. A trained yoga instructor led group participants through a routine specifically designed for women in their second and third trimester of pregnancy	Waitlist control	12	20	Weekly	Prenatal

Abbreviations: TAU = treatment as usual

3.3.4.1.1 Risk of Bias

Specific concerns for this study were related to the blinding of participants and personnel (high risk of bias) and randomization procedures, allocation concealment, and blinding of outcome assessors (all rated unclear risk of bias).

3.3.4.1.2 Depressive Symptoms

One study (Field 2013) measured depressive symptoms at the end of treatment using the Center for Epidemiology Depression Scale (CES-D). There was no difference in depressive symptoms between the exercise and TAU groups (SMD -0.04, 95% CI -0.49 to 0.41) (Appendix Table F-55).

3.3.4.1.3 Anxiety Symptoms

One study (Field 2013) measured anxiety symptoms at the end of treatment using the STAI. There were no differences in anxiety symptoms among participants who received the exercise intervention compared with TAU (SMD 0.18, 95% CI -0.27, 0.63) (Appendix Table F-56).

3.3.4.2 CBT Versus TAU

Three studies compared CBT with TAU among participants with both depressive and anxiety disorders (Table 21), all interventions were designed to be transdiagnostic (addressing both depressive and anxiety symptoms). One study (Green 2020) tested a group CBT intervention, which ran for 120 minutes and was delivered weekly for 6 weeks. Two studies tested the same 3 sessions of online self-guided CBT (Loughan 2019 [PMID 30266030] and Loughan 2019 [PMID 30877878]). Both studies were self-paced, but one required participants to complete all sessions within a 4-week period, whereas the other required participants to complete all sessions in a 6-

3.3.4 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive and Anxiety Disorders

week period. Two studies (Green 2020 and Loughnan 2019 [PMID 30266030]) included participants in the prenatal period and Loughnan 2019 [PMID 30877878] included participants in the postnatal period.

Outcomes included: depressive and anxiety symptoms, stress, and worry.

Table 21. CBT versus TAU for depressive and anxiety disorders: Description of interventions and comparisons

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Green, 2020, 31957479 ⁹⁸	Group CBT intervention delivered by mental health professional, designed to be transdiagnostic. Session content was tailored to meet the needs of perinatal individuals with anxiety and depression. Learning was reinforced with weekly homework	Waitlist control	6	120 minutes	Weekly	Prenatal
Loughnan, 2019, 30266030 ¹⁰⁶	Online, self-guided CBT. Designed to be transdiagnostic	Usual care. Participants continued to access usual care from local health services. Participants only received clinical contact if they experienced a worsening in distress, depression or suicide ideation during the study assessment	3	NR	Self-paced (to be completed in 4 weeks)	Prenatal
Loughnan, 2019, 30877878 ¹⁰⁵	Online, self-guided CBT. Designed to be transdiagnostic. Included information on postpartum anxiety and depression, identifying unhelpful thoughts, dealing with uncertainty, addressing unhelpful behaviors, and building confidence.	Usual care. Participants continued to access usual care from local health services. Participants only received clinical contact if they experienced a worsening in distress, depression or suicide ideation during the study assessment	3	NR	Self-paced (to be completed in 6 weeks)	Postnatal

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, NR = not reported.

3.3.4 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive and Anxiety Disorders

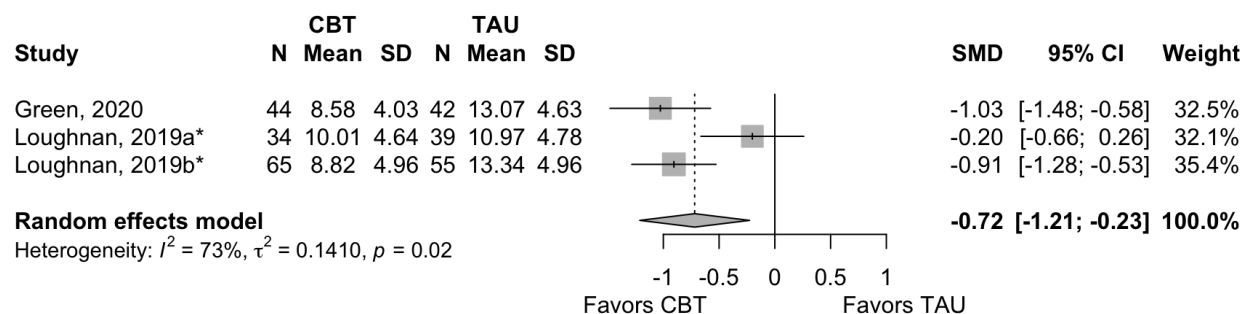
3.3.4.2.1 Risk of Bias

Specific concerns were related to the blinding of participants and personnel (3/3 high risk of bias), intention-to-treat analysis (1/3 high and 2/3 low risk of bias), and blinding of outcome assessors (2/3 unclear and 1/3 low risk of bias). All other domains were rated low risk of bias.

3.3.4.2.2 Depressive Symptoms

Three studies compared depressive symptoms among participants with anxiety and depression between those who received CBT and those who received TAU. A meta-analysis (Figure 21) provided evidence that depressive symptoms at the end of treatment differed significantly between those who received CBT compared with those who received TAU (summary SMD -0.72 , 95% CI -1.21 to -0.23 , I^2 73%). Studies were inconsistent, with two favoring CBT and one indicating no statistical difference between groups. Study effect sizes and the summary SMD are imprecise.

Figure 21. CBT versus TAU for depressive and anxiety disorders: Depressive symptoms at the end of treatment



*Reported estimated marginal means

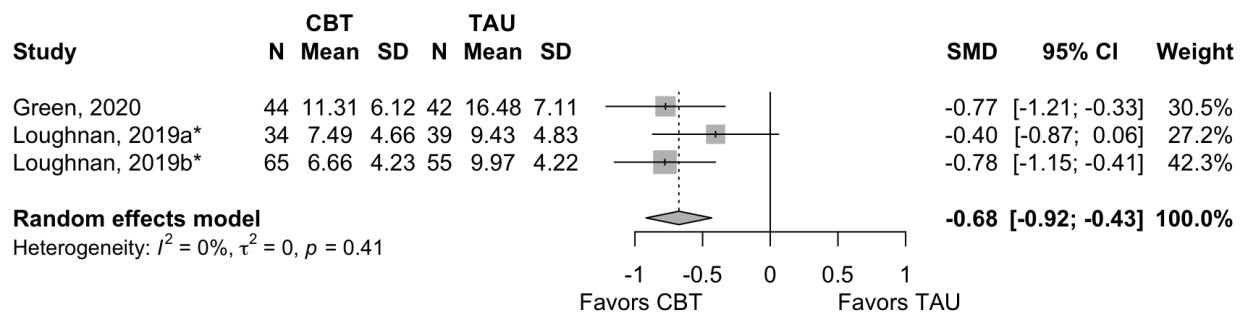
Abbreviations. CI = confidence interval, CBT = cognitive behavioral therapy, SD = standard deviation, SMD = standardized mean difference, TAU = treatment as usual.

3.3.4.2.3 Anxiety Symptoms

Three studies compared anxiety symptoms at the end of treatment between participants who received CBT and participants who received TAU. A meta-analysis (Figure 22) provided evidence that symptoms of anxiety were significantly lower in the CBT group compared with TAU (summary SMD -0.68 , 95% CI -0.92 to -0.43 , I^2 0%).

3.3.4 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive and Anxiety Disorders

Figure 22. CBT versus TAU for depressive and anxiety disorders: Anxiety symptoms at the end of treatment



*Reported estimated marginal means

Abbreviations. CI = confidence interval, CBT = cognitive behavioral therapy, SD = standard deviation, SMD = standardized mean difference, TAU = treatment as usual

3.3.4.2.4 Worry

One study (Green 2020) reported on participants' levels of worry at the end of treatment. Worry was assessed using the Penn State Worry Questionnaire (PSWQ). Participants in the CBT group reported significantly less feelings of worry at the end of treatment compared with the TAU group (SMD -1.28 , 95% CI -1.72 to -0.82) (Appendix Table F-57).

3.3.4.2.5 Stress

One study (Green 2020) reported on participants' levels of perceived stress at the end of treatment, as rated on the Perceived Stress Scale. Perceived stress scores were lower in the CBT group at the end of treatment compared with the TAU group (SMD -1.12 , 95% CI -1.57 to -0.66) (Appendix Table F-58).

3.3.5 KQ 1: Nonpharmacologic Treatments for Depressive and/or Anxiety Disorders

We identified two studies that tested nonpharmacologic treatments in individuals who had either (or both) depressive or anxiety disorders, without providing separate results for participants with depressive disorders alone, anxiety disorder alone, or both disorders. Both studies compared CBT with TAU. Table 22 summarizes the SoE for studies comparing nonpharmacologic treatments for depressive or anxiety disorders.

3.3.5 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive and/or Anxiety Disorders

Table 22. KQ 1: Strength of evidence of nonpharmacologic treatments for depressive or anxiety disorders

Type of Outcome	Outcome ^a	Comparison	N Studies (Participants)	RoB	Consistency	Precision	Directness	Overall SoE	Conclusions
Scores of psychological assessments	Depression	CBT vs TAU	3 (305)	High	Inconsistent	Imprecise	Direct	Insufficient	No conclusions
	Anxiety	CBT vs TAU	3 (305)	High	Inconsistent	Imprecise	Direct	Insufficient	No conclusions

^aComparisons with three or fewer studies in total are omitted

Abbreviations: KQ = Key Question, CBT = cognitive behavioral therapy, TAU = treatment as usual, RoB = risk of bias, SoE = strength of evidence

3.3.5 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive and/or Anxiety Disorders

3.3.5.1 CBT Versus TAU

Three studies compared CBT with TAU among 305 participants who had either depressive or anxiety disorders (Table 23). Bittner 2014 tested a group CBT program consisting of 8 90-minute sessions. Burger 2020 tested an individual CBT program consisting of 10 to 14 sessions. Both interventions in the Bittner 2014 and Burger 2020 studies were delivered by psychologists. Canfield 2023 tested an online, self-guided CBT intervention, which consisted of 8 sessions. All three studies compared CBT with TAU, which was defined as a locally available prenatal care. All studies included participants in the prenatal period.

Outcomes include: depressive symptoms, anxiety symptoms, perceived social support, child behavioral scores, and satisfaction with treatment.

Table 23. CBT versus TAU for depressive or anxiety disorders: Description of interventions and comparisons

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Bittner, 2014, 25062520 ⁷⁹	Group CBT delivered by clinical psychologists. Consisted of psychoeducation, introduction to cognitive behavioral strategies, performance of exercises/role playing, and progressive muscle relaxation.	Usual care	8	90 minutes	NR	Prenatal
Burger, 2020, 31806071 ⁸¹	Individual CBT delivered by psychologists. Incorporated exposure, response prevention and cognitive challenging work, behavioral activation, imagery and rescripting	Usual care	10-14	NR	NR	Prenatal
Canfield, 2023, 37853333 ¹⁴³	Online, self-guided CBT. Included sessions on thoughts and mood, cognitive restructuring, engaging in pleasant activities, relaxation exercises, and guided mediation exercises.	Usual care.	8	NR	Weekly, self-paced	Prenatal

Abbreviations: CBT = cognitive behavioral therapy, NR = not reported, TAU = treatment as usual

3.3.5.1.1 Risk of Bias

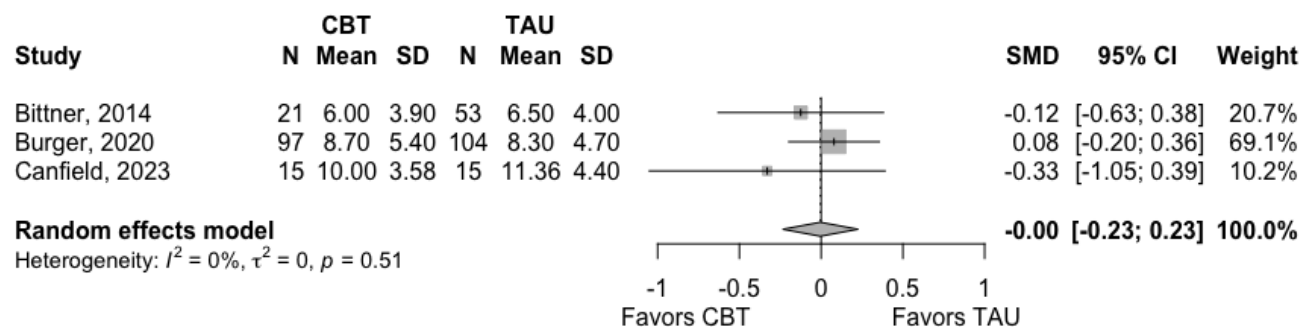
Specific concerns regarding the risk of bias were related to blinding of participants (3/3 high risk of bias) and attrition bias (2/3 high and 1/3 low risk of bias). One study (Canfield 2023) was rated high risk of selection bias due to allocation concealment. All other domains were rated low risk of bias.

3.3.5 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive and/or Anxiety Disorders

3.3.5.1.2 Depressive Symptoms

Three studies (Bittner 2014, Burger 2020, and Canfield 2023) assessed depressive symptoms at the end of treatment using the EPDS. A meta-analysis (Figure 23) provided insufficient evidence of equivalence between CBT and TAU (summary SMD 0.00, 95% CI -0.23 to 0.23 , I^2 0%). Studies were inconsistent, with Bittner 2014 and Canfield favoring CBT and Burger 2020 favoring TAU. All effect sizes were imprecise, as was the summary statistic.

Figure 23. CBT versus TAU for depressive or anxiety disorders: Depressive symptoms at the end of treatment

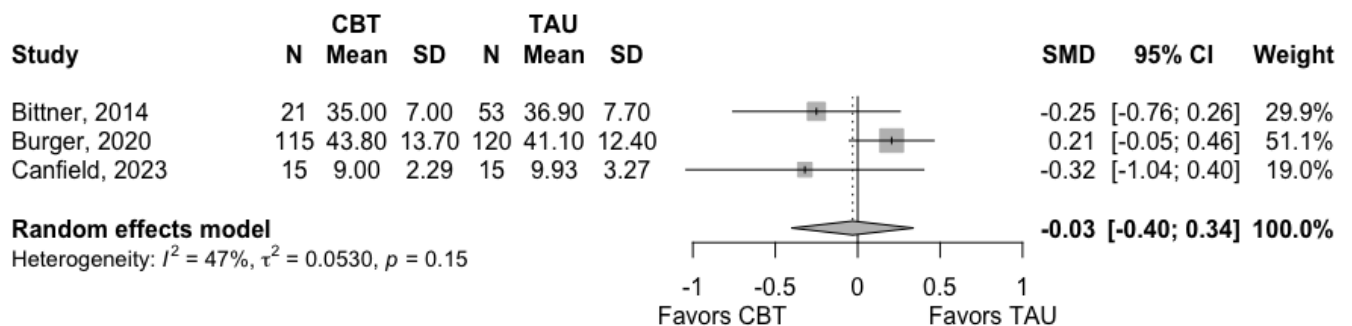


Abbreviations. CI = confidence interval, CBT = cognitive behavioral therapy, SD = standard deviation, SMD = standardized mean difference, TAU = treatment as usual

3.3.5.1.3 Anxiety Symptoms

Three studies (Bittner 2014, Burger 2020, and Canfield 2023) assessed anxiety symptoms at the end of treatment using various measures. Bittner 2014 and Burger 2020 assessed anxiety symptoms using the STAI and Canfield used the GAD-7. A meta-analysis (Figure 24) provided insufficient evidence of equivalence between CBT and TAU for anxiety symptoms (summary SMD -0.03 , 95% CI -0.40 to 0.34 , I^2 47%). Studies were consistent in showing no difference in anxiety symptoms between groups, however they were all lacking precision. The summary estimate was also imprecise.

Figure 24. CBT versus TAU for depressive or anxiety disorders: Anxiety symptoms at the end of treatment



Abbreviations. CI = confidence interval, CBT = cognitive behavioral therapy, SD = standard deviation, SMD = standardized mean difference, TAU = treatment as usual

3.3.5 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for Depressive and/or Anxiety Disorders

3.3.5.1.4 Perceived Social Support

One study (Bittner 2014) assessed levels of perceived social support at the end of treatment. There were no differences in perceived social support between the CBT and TAU group (SMD 0.00, 95% CI -0.51 to 0.51) (Appendix Table F-59).

3.3.5.1.5 Child Emotional and Behavioral Difficulties

One study (Burger 2020) assessed child behavior scores on the Child Behavior Checklist at 18 months postpartum, where higher scores indicate greater emotional or behavioral problems. There were no differences in child behavior scores between children of mothers who received CBT compared with TAU (SMD 0.17, 95% CI -0.11 to 0.45) (Appendix Table F-60).

3.3.5.1.6 Satisfaction With Treatment

One study (Canfield 2023) assessed satisfaction with treatment for participants who received CBT treatment using the CSQ-8. Scores on the CSQ-8 range from 3 to 32, where a higher score indicates greater satisfaction with treatment. The mean CSQ-8 score among participants who received CBT was 26.0 (SD 2.68) out of a possible total of 32 (Appendix Table F-61).

3.3.5.2 Summary of Studies Included in the Evidence Map

Five RCTs^{151-153, 162, 166} tested interventions for participants with any combination of anxiety, depression, stress, and/or PTSD. Hamilton 2021 reported that cognitive analytic therapy was more effective than TAU in treating anxiety symptoms. Heller 2020 reported that problem solving-therapy was more effective than TAU in treating anxiety symptoms. Horwitz 2015 reported that there was no difference between trauma-focused CBT and TAU. Richter 2012 and Suchan 2022 found CBT and psychoeducation was more effective in treating anxiety symptoms compared with TAU.

3.3.6 KQ 1: Nonpharmacologic Treatments for PTSD

Six studies evaluated the effectiveness of several treatment approaches on PTSD, including CBT (3 studies), eye movement desensitization and reprocessing (EMDR) (1 study), psychoeducation (1 study) and non-directive-counseling (1 study). The SoE of nonpharmacologic treatments for PTSD is summarized in Table 24.

3.3.6 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for PTSD

Table 24. KQ 1: Strength of evidence of nonpharmacologic treatments for PTSD

Type of Outcome	Outcome ^a	Comparison	N Studies (Participants)	RoB	Consistency	Precision	Directness	Overall SoE	Conclusions
Scores of psychological assessments	Depression	CBT vs TAU	3 (185)	Moderate	Inconsistent	Imprecise	Direct	Insufficient	No conclusions
	Depression	EMDR vs TAU	1 (37)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions
	Anxiety	CBT vs TAU	3 (197)	Moderate	Inconsistent	Imprecise	Direct	Insufficient	No conclusions
	Anxiety	EMDR vs TAU	1 (59)	Unclear	N/A	Imprecise	Direct	Insufficient	No conclusions
	Trauma symptoms	CBT vs TAU	2 (156)	Moderate	Inconsistent	Imprecise	Direct	Insufficient	No conclusions
	Trauma symptoms	EMDR vs TAU	1 (37)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions
	Trauma symptoms	EDU vs TAU	1 (138)	Moderate	N/A	Imprecise	Direct	Insufficient	No conclusions
	Trauma symptoms	COUN vs TAU	1 (103)	Moderate	Inconsistent	Imprecise	Direct	Insufficient	No conclusions
Cure/ resolution of symptoms	Depression	CBT vs TAU	1 (103)	Moderate	Inconsistent	Imprecise	Direct	Insufficient	No conclusions
	Depression	COUN vs TAU	1 (103)	Moderate	Inconsistent	Imprecise	Direct	Insufficient	No conclusions
Adherence	Adherence	EMDR vs TAU	1 (87)	Moderate	N/A	N/A	N/A	Insufficient	No conclusions

^aComparisons with three or fewer studies in total are omitted

Abbreviations: KQ = Key Question, CBT = cognitive behavioral therapy, COUN = non-directive counseling, EMDR = eye movement desensitization and reprocessing, EDU = psychoeducation, N/A = not applicable, PTSD = post-traumatic stress disorder, RoB = risk of bias, SoE = strength of evidence, TAU = treatment as usual.

3.3.6 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for PTSD

3.3.6.1 CBT Versus TAU

Three studies tested a CBT intervention compared with TAU among participants with PTSD (Table 25). One study (Shaw 2014) tested an intervention for mothers of preterm infants in the neonatal intensive care unit. All CBT treatments were trauma-focused and delivered by mental health professionals, two were delivered individually and one was a group CBT treatment. The number of sessions ranged between 8 and 12. Two delivered the CBT intervention on a weekly basis and one study did not report of the frequency of the CBT sessions. Two studies (Nieminen 2016 and Shaw 2014) included participants in the postnatal period and Madigan 2015 included participants in the prenatal period.

Outcomes included: anxiety symptoms, depressive symptoms, quality of life and symptoms of trauma.

Table 25. CBT versus TAU for PTSD: Description of interventions and comparisons

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Madigan, 2015, 25703488 ¹⁰⁷	Individual trauma-focused CBT delivered by a mental health professional. Consists of psychoeducation, stress management, affect expression and modulation, cognitive coping, creating the trauma narrative, and cognitive processing (of the trauma narrative) along with a parenting course	Usual care and the same parenting course delivered to the CBT group	12	60 minutes	Weekly	Prenatal
Nieminen, 2016, 27152849 ¹¹⁶	Online trauma-focused CBT delivered by a therapist. Consists of psychoeducation, anxiety coping methods and skill training, imaginary and in vivo exposure, and cognitive restructuring	Waitlist control	8	NR	Weekly	Postnatal

3.3.6 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for PTSD

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Shaw, 2014, 25049338 ¹²⁴	Individual trauma-focused CBT for mothers of pre-term infants. Delivered by social workers or psychologists. Intervention focused on at identifying triggers associated with the development of parental trauma symptoms as well as education about parenting patterns associated with the aspects of the vulnerable child syndrome	Usual care. Participants received a one-off 45-minute information session about NICU policy and procedures	9 or 6	NR	NR	Postnatal

Abbreviations: CBT = cognitive behavioral therapy, NICU = neonatal intensive care unit, NR = not reported, PTSD = post-traumatic stress disorder, TAU = treatment as usual.

3.3.6.1.1 Risk of Bias

Specific concerns were related to the blinding of participants and personnel (3/3 high risk of bias), the blinding of outcome assessors (1/3 high and 2/3 unclear risk of bias). All other domains were rated low risk of bias.

3.3.6.1.2 Anxiety Symptoms

Three studies (Niemi 2016, Shaw 2014 and Madigan 2015) included measures of anxiety symptoms at the end of treatment and followup. One study (Shaw 2014) did not report raw anxiety scores on the BAI, instead they reported effect sizes as Cohen's d, without reporting a measure of error (e.g. confidence interval) therefore, meta-analysis was not feasible. Where it was possible to calculate SMDs, there was no difference in anxiety symptoms between the CBT and TAU groups at the end of treatment (Niemi 2016 SMD -0.18, 95% CI -0.71 to 0.34; Madigan 2015 SMD 0.11, 95% CI -0.60 to 0.72). There was no significant difference in anxiety symptoms at 1 year followup between the CBT and TAU groups, as reported by Madigan 2015 (SMD 0.55, 95% CI -0.24 to 1.33) On the other hand, Shaw 2014 reported anxiety symptoms were lower in the CBT group at the end of treatment (SMD [Cohen's d] -0.19, 95% CI not reported) (Appendix Table F-62).

3.3.6.1.3 Depressive Symptoms

Three studies (Madigan 2015, Niemi 2016, and Shaw 2014) reported on depressive symptoms at the end of treatment and followup. One study (Shaw 2014) did reported scores on the BDI as Cohen's d, without measures of error. therefore, meta-analysis was not feasible. There was no significant difference in depression symptoms at the end of treatment (Madigan 2015 SMD 0.62, 95% CI -0.10 to 1.35 and Niemi 2016 SMD -0.26, 95% CI -0.79 to 0.27) or 1 year followup (SMD 0.73, 95% CI -0.07 to 1.53) between the CBT and TAU groups, On

3.3.6 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for PTSD

the other hand, Shaw 2014 reported anxiety symptoms were lower in the CBT group at the end of treatment (SMD [Cohen’s d] –0.56, 95% CI not reported) (Appendix Table F-63).

3.3.6.1.4 Quality of Life

One study (Nieminen 2016) assessed quality of life after intervention period using the Quality-of-Life Inventory and EQ-5D at the end of treatment. No differences between the CBT and TAU groups were observed on either measure (Quality of Life Inventory SMD –0.07, 95% CI –0.59 to 0.45, and EQ-5D –0.09, 95% CI –0.61 to 0.44) (Appendix Table F-64).

3.3.6.1.5 Symptoms of Trauma

Two studies (Nieminen 2016 and Shaw 2014) measured symptoms of trauma at the end of treatment and 26-week followup. Nieminen 2016 reported that trauma symptoms, as rated by the Impact of Events scale, were lower in the CBT group at the end of treatment compared with the TAU group (SMD –0.85, 95% CI –1.41 to –0.31) (Appendix Table F-65).

3.3.6.2 Eye Movement Desensitization and Reprocessing Versus TAU

One study (Chiorino 2020) tested an EMDR intervention for participants experiencing symptoms of PTSD following childbirth (Table 26). EMDR was delivered as a one-time intervention, by a trained practitioner, in the mother’s room in the maternity ward up to 3 days following the birth. TAU was defined as the hospital’s usual care procedures for mothers experiencing PTSD symptoms following delivery. TAU consisted of a one-time psychological consultation. Participants were in the postnatal period.

Outcomes included: symptoms of trauma and parent-infant bonding.

Table 26. EMDR versus TAU for PTSD: Description of interventions and comparisons

Study, Year, PMID	Description of EMDR	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Chiorino, 2020, 31805778 ⁸⁴	EMDR delivered by a trained practitioner, in the participants room in the maternity ward, between one and three days after child birth	Usual care. Standard supportive psychological consultation delivered in the maternity ward	1	90 min	One-time	Postnatal

Abbreviations: EMDR = eye movement desensitization and reprocessing, PTSD = post-traumatic stress disorder, TAU = treatment as usual

3.3.6.2.1 Risk of Bias

The only domain of concern was related to the blinding of participants and personnel, which was rated high risk of bias. All other domains were rated low risk of bias.

3.3.6.2.2 Symptoms of Trauma (Impact of Events Scale)

One study (Chiorino 2020) reported on participants symptoms of trauma using the Impact of Events Scale at the end of treatment and at 12-week followup. Symptoms of trauma were lower in the EMDR group at the end of treatment (SMD –0.69, 95% CI –1.35 to –0.02) and followup (SMD –0.73, 95% CI –1.39 to –0.06) (Appendix Table F-66).

3.3.6 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for PTSD

3.3.6.2.3 Parent-Infant Bonding

One study (Chiorino 2020) reported on the parent-infant bond, using the mother-to-infant bonding scale. There was no difference in parenting-infant bonding scores between the EMDR and TAU groups at the end of treatment (SMD -0.27 , 95% CI -0.92 to 0.38) or 12-week followup (SMD -0.31 , 95% CI -0.96 to 0.34) (Appendix Table F-67).

3.3.6.3 Psychoeducation Versus TAU

One study tested a psychoeducation program compared with TAU for participants experiencing PTSD (Table 27). The psychoeducation intervention provided information on understanding the causes and effects of PTSD, and managing relationships, time, and anger,

Table 27. CBT versus TAU for PTSD: Description of interventions and comparisons

Study, Year, PMID	Description of Psychoeducation	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Upshur, 2016, 27480668 ¹²⁸	Individual psychoeducation. Titled 'Seeking Safety'. Included information regarding the concept of safety, self-care, understanding what PTSD and what issues it can cause, setting boundaries in relationships, scheduling time and managing anger	Usual care	NR	NR	NR	Prenatal and postnatal

Abbreviations: CBT = cognitive behavioral therapy, NR = not reported, PTSD = post-traumatic stress disorder, TAU = treatment as usual

3.3.6.3.1 Risk of Bias

Specific concerns were related to intention-to-treat analysis (high risk of bias) and randomization procedures, allocation concealment, blinding of participants and personnel, and blinding of outcome assessors (all rated unclear risk of bias).

3.3.6.3.2 Trauma Symptoms

One study (Upshur 2016) measured post-traumatic stress scores at the end of treatment. There was no difference in trauma symptoms between the psychoeducation and TAU groups (SMD -0.02 , 95% CI -0.35 to 0.32) (Appendix Table F-68).

3.3.6.3.3 Social Support

One study (Upshur 2016) assessed social support at the end of treatment using the social support scale from the medical outcomes study. No differences were observed in social support scores between the psychoeducation and TAU groups (SMD 0.09 , 95% CI -0.16 to 0.33) (Appendix Table F-69).

3.3.6 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for PTSD

3.3.6.4 Non-Directive Counseling Versus TAU

One study (Gamble 2005) compared counseling with TAU for participants with PTSD (Table 28). Participants received two counseling sessions, once 72 hours after the birth and once 4 to 6 weeks after the birth. Each counseling session lasted between 40 and 60 minutes, was delivered by a research midwife, and incorporated elements of critical stress debriefing. Participants were in the postnatal period.

Table 28. Counseling versus TAU for PTSD: Description of interventions and comparisons

Study, Year, PMID	Description of Counseling	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Gamble, 2005, 15725200 ⁹⁷	Non-directive counseling with research midwife, within 72 hours of the birth and 4 to 6 weeks after the birth. Counseling incorporated elements of critical stress debriefing	Usual care	2	40 to 60 minutes	Two-time	Postnatal

Abbreviations: PTSD = post-traumatic stress disorder, TAU = treatment as usual

3.3.6.4.1 Risk of Bias

Specific concerns were related to the blinding of participants and personnel (high risk of bias), and selective reporting (unclear risk of bias). All other domains were rated low risk of bias.

3.3.6.4.2 Remission Rate of Depressive Symptoms

One study (Gamble 2005) measured the remission rate of depressive symptoms at the end of treatment and 12-week followup. Remission was defined a score below 12 on the EPDS. There was no difference in the proportion of participants who reached remission between the counseling and TAU groups at the end of treatment (RR 0.94, 95% CI –0.54 to 1.64) or at 6-month followup (RR 0.25, 95% CI 0.09 to 0.69) (Appendix Table F-70).

3.3.6.4.3 Remission Rate of Anxiety Symptoms

Gamble 2005 assessed the proportion of participants who reach remission for anxiety symptoms at the end of treatment. Remission was defined as a score below 9 on the Depression, Anxiety, Stress Scale (DASS) anxiety subscale. There was no difference in the proportion of participants who reached remission between the counseling and TAU groups (RR 0.18 95% CI 0.02 to 1.42) (Appendix Table F-71).

3.3.6.4.4 Symptoms of Trauma

One study (Gamble 2005) assessed symptoms of trauma at the end of treatment and 12-week followup using the Mini-International Neuropsychiatric Interview–Post-Traumatic Stress Disorder scale (MINI-PTSD). There was no difference in symptoms of trauma between the counseling and TAU groups at the end of treatment (SMD –0.19, 95% CI –0.58 to 0.20). However, symptoms of trauma were lower in the counseling group at 12-week followup than the TAU group (SMD –0.42, 95% CI –0.81 to –0.02) (Appendix Table F-72).

3.3.6 Results, KQ 1: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for PTSD

3.3.6.4.5 Remission Rate of PTSD

Gamble 2005 assessed the proportion of participants who reach remission for anxiety symptoms at the end of treatment and 12-week followup, as defined by DSM-IV-R criteria for PTSD. The estimates of effect of counseling on remission imprecise: at the end of treatment (RR 1.13, 95% CI 0.64 to 1.98) or 12-week followup (RR 0.35, 95% CI 0.10 to 1.23) (Appendix Table F-73).

3.3.7 KQ 1: Nonpharmacologic Treatments for OCD

We identified one study testing a nonpharmacologic treatment for perinatal individuals with OCD. Challacombe 2017 compared CBT with TAU. The SoE of nonpharmacologic treatments for OCD is summarized in Table 29.

Table 29. KQ 1: Strength of evidence of nonpharmacologic treatments for OCD

Type of Outcome	Outcome ^a	Comparison	N Studies (Participants)	RoB	Consistency	Precision	Directness	Overall SoE	Conclusions
Scores on psychological assessments	Obsessive-compulsive symptoms	CBT vs TAU	1 (33)	High	Consistent ^b	Imprecise	Direct	Insufficient	No conclusions

^aComparisons with three or fewer studies in total are omitted

^bOne study used two outcomes of obsessive-compulsive symptoms.

Abbreviations: KQ = Key Question, CBT = cognitive behavioral therapy, OCD = obsessive compulsive disorder, RoB = risk of bias, SoE = strength of evidence, TAU = treatment as usual

3.3.7.1 CBT Versus TAU

Challacombe 2017 tested an online therapist-led CBT intervention (Table 30). Participants received four sessions, each lasting 3 hours, over a 2-week period. TAU could include CBT or other psychological therapies as recommended by the participant's usual care provider. Participants were in the postnatal period.

Outcomes included obsessive-compulsive symptoms and parent-infant bonding.

Table 30. CBT versus TAU for OCD: Description of interventions and comparisons

Study, Year, PMID	Description of CBT	Description of TAU	Total Number of Sessions	Average Duration of Sessions	Frequency	Perinatal Period
Challacombe, 2017, 28137316 ⁸³	Individual, online CBT delivered by a therapist.	Usual care. Some participants received CBT as part of usual care	4	3 hours	All sessions over a 2-week period	Postnatal

Abbreviations: CBT = cognitive behavioral therapy, OCD = obsessive compulsive disorder, TAU = treatment as usual

3.3.7.1.1 Risk of Bias

Specific concerns were related to the blinding of participants and personnel and intention-to-treat analysis (both rated high risk of bias). We rated this study has high risk of bias regarding

3.3.7 Results, KQ 2: Comparative Effectiveness of Nonpharmacologic Treatments, KQ 1: Nonpharmacologic Treatments for OD

intention-to-treat analysis as participants in the TAU group may have also received CBT intervention during the study period. All other domains were rated low risk of bias.

3.3.7.1.2 Obsessive-Compulsive Symptoms

Challacombe 2017 compared levels of obsessive-compulsive symptoms at the end of treatment using the Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) and the Obsessive-Compulsive Inventory (OCI). Obsessive compulsive-symptoms were lower in the CBT group at the end of treatment compared with the TAU group on both measures (Y-BOCS SMD -0.90 , 95% CI -1.62 to -0.18 ; OCI SMD -0.92 , 95% CI -1.64 to -0.20) (Appendix Table F-74).

3.3.7.1.3 Parent-Infant Bonding

Challacombe 2017 assessed the parent-infant bond using the Ainsworth sensitivity scales. There was no difference in the parent infant bond between the CBT and TAU groups (SMD 0.09 , 95% CI -0.60 to 0.79) (Appendix Table F-74).

3.3.8 Nonpharmacologic Treatments for Bipolar Disorder

No studies compared tested nonpharmacologic treatments for participants with bipolar disorder.

3.4 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments

3.4.1 Key Points

- We identified a limited number of studies comparing nonpharmacologic to pharmacologic treatments for the perinatal population
- Two studies compared the effectiveness of nonpharmacologic treatments versus selective serotonin reuptake inhibitors (SSRIs) for depressive disorders. Both studies found that CBT or SSRIs reduced depressive symptoms at the end of treatment. In one study, the reduction of depressive symptoms was greater among individuals who received CBT.
- We did not find any studies assessing the harms of nonpharmacologic treatments compared to pharmacologic treatments
- Due to the limited evidence on this topic, it is not possible to draw conclusions regarding the comparative effectiveness of nonpharmacologic treatments compared with pharmacologic treatments

3.4.2 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for Depressive Disorders

Two studies evaluated the comparative effectiveness of nonpharmacologic and pharmacologic treatments (Milgrom 2015 and Sharp 2010) among participants with depressive disorders. Due to the limited number of studies identified, only the primary findings of these studies were extracted and a risk of bias assessment was not conducted (Appendix Table C-2).

3.4.2 Results, KQ 2: Nonpharmacologic Versus Pharmacologic Treatments, KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for Depressive Disorders

Sharp 2010 compared anti-depressant treatment (SSRIs were recommended) to non-directive counseling. There was no significant difference in depressive symptoms at the end of treatment between those randomized to antidepressants and those randomized to non-directive counseling.

Milgrom 2015 conducted a 3-arm RCT comparing CBT, SSRIs, and CBT with SSRIs. Depressive symptoms were reduced in all 3 study arms at the end of treatment, however a greater reduction in depressive symptoms was identified in the CBT arm compared to the SSRI and CBT with SSRI arms.

3.4.3 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for Anxiety Disorders

No studies compared nonpharmacologic treatments with pharmacologic treatments among participants with anxiety disorders.

3.4.4 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for PTSD

No studies compared nonpharmacologic treatments with pharmacologic treatments among participants with PTSD.

3.4.5 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for OCD

No studies compared nonpharmacologic treatments with pharmacologic treatments among participants with OCD.

3.4.6 KQ 2: Nonpharmacologic Versus Pharmacologic Treatments for Bipolar Disorder

No studies compared nonpharmacologic treatments with pharmacologic treatments among participants with bipolar disorder.

4. Discussion

4.1 Key Findings

Given the potential risks of adverse outcomes following untreated depression, anxiety, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), or bipolar disorder during the perinatal period, decision makers need information on how to best manage such mental health conditions.

We identified a large body of evidence assessing the comparative effectiveness of nonpharmacologic treatments for perinatal mental health conditions, including 104 randomized controlled trials (RCTs) reported in 115 articles. The studies included in this review assessed a wide range of treatments with differing delivery characteristics, among a variety of mental health conditions, and evaluated the effectiveness of such treatments using numerous different outcome measures. Our overall findings, including strength of evidence (SoE) assessment, regarding the effectiveness of nonpharmacologic treatments for depressive or anxiety disorders are summarized in Table 31.

4. Discussion

Table 31. KQ 1: Summary of nonpharmacologic treatments for depressive or anxiety disorders by treatment type

Intervention	Population	Outcome	Conclusion Effect Size (95% CI)	Back-Transformed Scale and Effect Size (95% CI)	Strength of Evidence
Behavioral activation vs. TAU	Depressive disorders	Reduced depressive symptoms	Behavioral activation more effective SMD -0.50(-0.68, -0.33)	EPDS -1.53 (-2.07, -1.01)	Low
CBT vs. counseling	Depressive disorders	Reduced depressive symptoms	No difference SMD -0.16 (CI -0.44, 0.11)	EPDS -0.49 (-1.34, 0.34)	Low
CBT vs. TAU	Combined depressive and anxiety disorders	Anxiety symptoms	CBT more effective SMD -0.68 (-0.92, -0.43)	STAI -6.97 (-9.43, -4.41)	Low
	Combined depressive and anxiety disorders	Reduced depressive symptoms	CBT more effective SMD -0.72 (-1.21, -0.53)	EPDS -2.20 (-3.69, 1.62)	Low
	Depressive disorders	Reduced anxiety symptoms	CBT more effective SMD -0.55 (-0.67, -0.44)	STAI -5.64 (-7.07, -4.30)	Moderate
	Depressive disorders	Reduced depressive symptoms	CBT more effective SMD -0.56 (-0.69, -0.42)	EPDS -1.71 (-2.10, -1.28)	Moderate
	Depressive disorders	Remission of depressive symptoms	CBT more effective RR 1.73 (1.33, 2.26)	N/A	Low
	Depressive or anxiety disorders	Reduced anxiety symptoms	No conclusions SMD -0.03 (-0.04 to 0.34)	STAI -0.31 (-0.41, -3.48)	Insufficient evidence
	Depressive or anxiety disorders	Reduced depressive symptoms	No conclusions SMD 0.00 (-0.23 to 0.23)	EPDS 0.00 (-0.70, 0.70)	Insufficient evidence
Counseling vs. TAU	Depressive disorders	Reduced depressive symptoms	No difference SMD -0.25 (-0.53, 0.02)	EPDS -0.76 (-1.62, 0.06)	Low
Exercise vs. TAU	Depressive disorders	Reduced depressive symptoms	Exercise more effective SMD -0.41 (-0.74, -0.08)	EPDS -1.25 (-2.26, -0.24)	Moderate

4. Discussion

Intervention	Population	Outcome	Conclusion Effect Size (95% CI)	Back-Transformed Scale and Effect Size (95% CI)	Strength of Evidence
IPT vs. TAU	Depressive disorders	Reduced anxiety symptoms	IPT more effective SMD -0.67 (-1.26, -0.99)	STAI -7.84 (-12.19, -2.15)	Low
	Depressive disorders	Reduced depressive symptoms	IPT more effective SMD -0.56 (-0.89, -0.22)	EPDS -1.80 (-2.71, -0.67)	Moderate
	Depressive disorders	Remission of depressive symptoms	IPT more effective RR 1.22 (1.04, 1.43)	N/A	Low
Specific vs. nonspecific acupuncture	Depressive disorders	Remission of depressive symptoms	Specific acupuncture more effective RR 1.48 (1.00, 2.19)	N/A	Low

Abbreviations: KQ = Key Question, CBT = cognitive behavioral therapy, CI = confidence interval, IPT = interpersonal therapy, RR = relative risk, SMD = standardized mean difference, SoE = strength of evidence, TAU = treatment as usual, EPDS = Edinburgh Postnatal Depression Scale, STAI = State Trait Anxiety Inventory, N/A = not applicable

4. Discussion

For **Key Question (KQ) 1** (effectiveness and comparative effectiveness of nonpharmacologic treatments) the most frequently used **psychological assessments** were measures of depressive or anxiety symptoms at the end of treatment. The most commonly tested intervention was cognitive behavioral therapy (CBT). When compared with treatment as usual (TAU), CBT was found to be more effective in treating depressive symptoms for individuals with depressive disorders (moderate SoE), anxiety symptoms for individuals with depressive disorders (moderate SoE), and anxiety and depressive symptoms for individuals with combined depressive and anxiety disorders (low SoE). Due to imprecise summary estimates, there was insufficient evidence for determining equivalence between CBT and non-directive counseling and non-directive counseling and TAU. Interpersonal therapy (IPT) was the next most frequently tested intervention and was found to be more effective than TAU in treating depressive symptoms (moderate SoE) and anxiety symptoms (low SoE) for individuals with depressive disorders. Exercise interventions were deemed to be more effective in treating depressive symptoms for individuals with depressive disorders (moderate SoE), as was behavioral activation (low SoE) when compared with TAU. Acupuncture was more effective in treating depressive symptoms compared with sham-acupuncture (low SoE). There was insufficient evidence for determining equivalence between bright light therapy and placebo light therapy or CBT compared to TAU for individuals with depressive or anxiety disorders.

The largest change in Edinburgh Postnatal Depression Scale (EPDS) score was found for CBT versus TAU for combined depressive and anxiety disorders and depressive disorders alone (the back-transformed effect sizes are summarized in Table 31). The largest change in State Trait Anxiety Inventory (STAI) scores was found for IPT versus TAU for depressive disorders and CBT versus TAU for combined depressive and anxiety disorders.

Regarding the **cure or resolution of symptoms** following the delivery of nonpharmacologic treatments, remission rates for depressive symptoms were higher among individuals who received CBT compared with TAU (low SoE), IPT compared with TAU (low SoE), and higher among individuals who received specific acupuncture compared with nonspecific acupuncture (low SoE). Studies assessing remission rates of depressive symptoms were generally rated high risk of bias due to their small sample sizes, therefore they may not be adequately powered to detect true differences in remission rates between study arms.

We did not identify sufficient evidence to draw conclusions regarding the comparative effectiveness of nonpharmacologic interventions for **parent-infant bonding, suicide-related outcomes, or adherence to treatment**.

The majority of studies tested nonpharmacologic studies for individuals with depressive, with several evaluating patients with combined depressive and anxiety disorders. One RCT found a multicomponent intervention effectively treated anxiety symptoms for people with **anxiety disorders**. We identified six RCTs testing the comparative effectiveness of nonpharmacologic treatments for individuals with **PTSD**, however it was not possible to draw conclusions regarding the comparative effectiveness of such interventions due to the diversity of interventions and outcomes used and, thus, insufficient levels of evidence for each comparison. Similarly, we only identified one small study testing a nonpharmacologic treatment for perinatal individuals with **OCD**, which also provided insufficient evidence to draw conclusions. We did not identify any studies testing nonpharmacologic treatments for individuals with **bipolar disorder**. We did not find any studies assessing the potential harms of nonpharmacologic treatments for any intervention in any perinatal mental health population.

4. Discussion

We identified two small RCTs addressing **KQ 2** (effectiveness of nonpharmacologic treatment compared with pharmacologic treatment). Due to the sparseness of evidence identified for KQ 2, it is not possible to draw conclusions regarding the comparative effectiveness of nonpharmacologic and pharmacologic treatment. We did not find any studies assessing the potential harms of nonpharmacologic compared to pharmacologic treatments.

4.2 Findings in Relation to What Is Already Known

4.2.1 KQ 1: Nonpharmacologic Treatments for Depressive Disorders

CBT, IPT, exercise and behavioral activation each effectively treated depressive symptoms for individuals with depressive disorders when compared with TAU. Similarly, CBT and IPT reduced anxiety symptoms among individuals with depressive disorders compared with TAU. CBT and IPT were also associated with increased rates of remission of depressive symptoms for individuals with depressive disorders compared with TAU.

Our findings regarding the effectiveness of **CBT** compared with TAU for treating psychological symptoms of individuals with perinatal depressive disorders are consistent with recent systematic reviews,^{179, 180} which concluded that CBT was more effective in treating depressive and anxiety symptoms among individuals with depressive disorders. However, one of the systematic reviews¹⁷⁹ classified behavioral activation and problem-solving therapies as CBT interventions, which may affect the interpretation of their findings in regard to specific interventions. The current review builds on existing reviews in this area by establishing that effect sizes do not differ between studies using diagnostic or screening tools and between the mode of delivery or setting of CBT interventions, and providing greater detail about the evidence and gaps for multiple mental health conditions.

Our findings regarding the effectiveness of **IPT** interventions for perinatal individuals with depressive disorders, confirm and provide additional evidence to an existing review on this topic. A previous systematic review¹⁸¹ concluded that IPT was likely associated with reduced depressive and anxiety symptoms at the end of treatment; however, this review did not conduct meta-analyses. Our meta-analysis of studies comparing IPT with TAU, lend empirical support to prior findings and also demonstrate the effect sizes do not differ by the use of diagnostic or screening tools, or by the mode of delivery; indicating IPT can be delivered using multiple modalities and maintain effectiveness.

A previous systematic review of **exercise** interventions for perinatal individuals with depressive disorders concluded that exercise effectively reduced depressive symptoms compared with TAU.¹⁸² Our findings are consistent with the prior review's findings. Our review also implemented stricter inclusion criteria for defining a diagnosis of depression.

Behavioral activation is a common CBT technique, which has been found to be an effective treatment for depression in its own right.¹⁸³ However, the effectiveness of behavioral activation interventions for perinatal depressive disorders had yet to be explored. Our review found behavioral activation effectively reduced depressive symptoms when compared with TAU. Compared with CBT, behavioral activation could potentially be a more parsimonious, transportable, and cost-effective treatment for perinatal depressive disorders.¹⁸⁴

This review found remission rates of depressive symptoms were higher among those who received **acupuncture** compared with non-specific or sham comparison groups. Acupuncture aims to restore the flow of energy through the body by inserting and stimulating needles. A

4. Discussion

narrative review has suggested that acupuncture is an effective treatment for perinatal depressive disorders.⁴⁷ The findings of this review support these claims; however, the SoE was rated low. **Bright-light therapy** is another complementary therapy that has been tested for perinatal mental health disorders, however we identified insufficient evidence to draw conclusions due to a lack of consistency and precision among included. Larger, more rigorous trials testing complementary therapies are needed.

4.2.2 KQ 1: Nonpharmacologic Treatments for Anxiety Disorders

We identified two RCTs testing nonpharmacologic interventions for anxiety disorders. One study tested a multicomponent (problem-solving therapy, self-care, and psychoeducation) intervention compared to TAU for individuals with anxiety disorders and found no significant differences in depressive symptoms, quality of life or generalized anxiety symptoms (as measured by the Generalized Anxiety Disorders Scale [GAD-7]) between the groups.¹³⁸ However, they did find a small, statistically significant difference in pregnancy-related anxiety scores at the end of treatment in favor of the multicomponent intervention. Similarly, another study testing CBT compared to TAU found no differences in depressive or anxiety symptoms between the groups.¹⁴⁰ Due to the heterogeneity in interventions, we were unable to draw conclusions. Previous reviews have also highlighted the paucity of RCTs in this area.¹⁸⁵

Given that one study found a significant effect of a multicomponent intervention in reducing anxiety on a scale developed for pregnant populations but did not find a significant effect on a scale developed for the general population,¹³⁸ it is possible that anxiety scales created for the general population are not sensitive enough or validated for use in the perinatal population.

4.2.3 KQ 1: Nonpharmacologic Treatments for Depressive and/or Anxiety Disorders

We identified four studies comparing the effectiveness of nonpharmacologic treatments for perinatal individuals with combined depressive and anxiety disorders. Three studies compared **CBT** with TAU. Previous reviews have grouped studies of participants with both depressive and anxiety disorders and studies of participants with depressive or anxiety disorders together, without delineating between these distinct patient groups.^{52, 182}

Three studies compared CBT with TAU for individuals with depressive and anxiety disorders. CBT was associated with reduced anxiety symptoms, but not reduced depressive symptoms, at the end of treatment compared with TAU. These findings provide limited evidence that CBT could be an effective transdiagnostic (i.e., addressing both depressive and anxiety symptoms) intervention for perinatal depressive and anxiety disorders. One study compared exercise with TAU for perinatal depressive and anxiety disorders, however this evidence was not insufficient for drawing evidence-based conclusions,

Three studies compared CBT with TAU for individuals with depressive or anxiety disorders, however there was insufficient evidence available to draw conclusions.

4.2.4 KQ 1: Nonpharmacologic Treatments for PTSD

A previous systematic review included two studies testing nonpharmacologic treatments for perinatal individuals with PTSD,¹⁸⁶ however, these studies were analyzed alongside interventions for individuals with other anxiety and stress-related conditions and the authors did

4. Discussion

not delineate outcomes by mental health conditions. We identified a similar paucity of studies testing nonpharmacologic treatments for PTSD, with insufficient evidence available for drawing conclusions regarding the effectiveness of nonpharmacologic treatments for PTSD.

4.2.5 KQ 1: Nonpharmacologic Treatments for OCD

We identified one study testing the effectiveness of CBT with TAU for perinatal individuals with OCD. No previous reviews have been conducted in this area, perhaps reflecting the lack of primary research.

4.2.6 KQ 1: Nonpharmacologic Treatments for Bipolar Disorder

We did not identify any studies assessing the comparative effectiveness of nonpharmacologic treatments for individuals with bipolar disorder, nor have there been any prior reviews on this topic.

4.2.7 KQ 2: Nonpharmacologic Compared With Pharmacologic Treatment for Perinatal Mental Health Conditions

Previous reviews have assessed the comparative effectiveness of pharmacologic treatments for perinatal mental health disorders, however there is limited research comparing pharmacologic with nonpharmacologic treatments. We identified two RCTs comparing the effectiveness of selective serotonin reuptake inhibitors (SSRIs) to nonpharmacologic treatments for depressive disorders. Both studies found that both CBT and SSRIs reduced depressive symptoms at the end of treatment. One study found reported that the reduction in depressive symptoms was greater among individuals who received CBT compared to SSRIs alone and CBT combined with SSRIs. Further research is needed to confirm these findings.

4.3 Applicability

There are a number of factors that may affect the applicability of our findings. We aggregated findings from interventions conducted in a range of settings, which varied in terms of delivery, study population, and which outcome measures.

For KQ 1, 18/71 studies (25%) were conducted in the United States, which has important implications for what is considered treatment as usual. For most studies in this review, participants in the TAU had access to locally available services for individuals during the perinatal period. Locally available services can vary greatly between countries and healthcare providers. While some studies gave clear descriptions of what usual care would likely consist of, many did not. Furthermore, in most cases, participants in the TAU groups were not precluded from accessing other nonpharmacologic or pharmacologic treatment from their primary healthcare or obstetric care providers, which may have an impact on the effect sizes reported in this review. One would expect that studies with more “active” TAU, with more services available compared with other studies, would yield smaller differences with CBT and other active interventions.

The race and ethnicity of participants included in this review may differ from the general population in important ways, affecting the generalizability of these findings. Across studies, the largest proportion of participants (65.2%) were White, almost one-quarter (26.0%) were Black, 4.0% were Asian, 16.5% were Hispanic, and 7.5% were from other racial and ethnic groups. The

4. Discussion

effectiveness of nonpharmacologic treatments may vary by ethno-cultural background and by socioeconomic factors, including discrimination and minoritization, for which race categorization may be a partial proxy. Participants from different ethno-cultural backgrounds may hold differing beliefs regarding the nature and treatment of mental health conditions, which may result in different responses to nonpharmacologic therapies.

We aggregated studies that tested nonpharmacologic treatments delivered in a range of settings, including in a clinic, at the participants home, or remotely. It is possible that the effectiveness of treatments may vary greatly depending on the mode of delivery or setting. For interventions and comparisons with a more limited evidence base it was not possible to explore whether the study setting or mode of delivery affected their effectiveness. However, where sufficient data was available for studies comparing CBT with TAU and IPT with TAU among individuals with depressive disorders, we found no differences in effect sizes by intervention setting or mode of delivery.

Included studies used either diagnostic tools or screening tools to identify perinatal individuals with mental health conditions. Most studies ($n = 44$, 62%) used a diagnostic tool or criteria (such as Diagnostic and Statistical Manual of Mental Disorders [DSM] or International Classification of Diseases [ICD] criteria) to confirm the presence of a mental health condition. However, many studies relied on screening tools only. We restricted studies that used screening tools only to identify mental health disorders to those using a validated cutoff. However, many studies employed vastly different cutoffs and there is little consensus regarding what cutoff is likely to identify clinical levels of common mental health conditions for perinatal individuals on screening tools. Where different cutoffs were suggested by prior studies, we chose to use the most inclusive which may have implications for the applicability of our findings. For example, it is possible that interventions may be successful in treating perinatal individuals with less-severe depressive symptoms who would not be diagnosed with a depressive disorder, but may be less effective at treating those with clinically confirmed mental health conditions. Where sufficient data were available, we did conduct subgroup analyses to explore whether effect sizes differed between studies using diagnostic and screening tools to identify mental health conditions. For studies comparing CBT with TAU and IPT with TAU, we found small differences in summary effect sizes between these two sets of studies, but these indirect comparisons across studies do not rule out that real differences may exist.

Studies in this review employed a wide variety of outcome measures at different time-points. Where studies measured sufficiently similar domains, we calculated standardized mean differences (SMDs) for outcomes at the end of treatment. This allowed us to draw comparisons across studies, however some measures may be more relevant for perinatal individuals than others and important nuance may be lost by pooling effect sizes across different measures.

4.4 Strengths and Limitations

4.4.1 Strengths and Limitations of the Systematic Review Process

We followed contemporary standards for systematic reviews, including engagement with multiple types of stakeholders in defining and refining both KQs and careful adherence to current systematic review standards for protocol publication and registration, literature searching, screening, data extraction, risk of bias assessment, qualitative synthesis, quantitative synthesis, and SoE assessment.

4. Discussion

One of the biggest challenges in conducting this review was the heterogeneity of study populations, interventions, comparisons, and outcomes used by the eligible RCTs. To manage the heterogeneity in study populations we, in consultation with our domain experts and prior literature, determined cutoffs for identifying perinatal mental health conditions on validated screening tools *a priori*. However, it is important to note that there is very little consensus regarding the use of cutoffs to identify clinical mental health disorders and the cutoff used by this study may not be applicable to all perinatal populations.

To manage the heterogeneity in interventions and comparisons we implemented an intervention taxonomy which was applied by an expert in complex interventions and reviewed by clinical experts in our team. Our intervention taxonomy grouped interventions into broad categories, which allowed us to draw conclusions regarding the comparative effectiveness between interventions and comparisons groups. Decisions regarding how to classify and intervention could be challenging, especially when the details of the intervention were not well reported. We further managed the heterogeneity in interventions and comparisons by restricting full data extraction, risk of bias assessment, and analysis to comparisons with three or more studies, however this is an important limitation. For example, one limitation of the decision to restrict full data extraction to comparisons with three or more studies is that multi-component interventions were less likely to be fully extracted and analyzed, limiting the conclusions we can draw about these types of interventions. The key findings from such interventions are listed in the evidence map in Appendix Table C-1.

Studies reported wide range of outcomes and used multiple measures to address the same domains. We only combined measures which clearly assessed the same domain and calculated standardized mean differences. However, it is important to note that some outcome measures may be more appropriate for perinatal populations than others. Most studies in this review included outcomes measuring the benefits of nonpharmacologic treatments and few reported on the potential harms. Therefore, we are unable to draw conclusions regarding the potential harms of nonpharmacologic treatments during the perinatal period. Furthermore, effect-sizes are in this review are reported as standardized mean differences, which may not equate to a clinically important difference.

4.4.2 Strengths and Limitations of the Evidence Base

For several areas of this review, including those summarized in the evidence map, evidence was limited or entirely absent. The majority of studies in this review compared CBT with TAU among various perinatal mental health conditions.

We found very few studies testing the comparative effectiveness of nonpharmacologic treatments for individuals with anxiety PTSD or OCD. We did not identify any studies testing nonpharmacologic treatments for individuals with bipolar disorder and very few studies compared nonpharmacologic with pharmacologic treatments.

Studies included in this review differed in how they named, defined, and reported nonpharmacologic treatments, making it challenging to determine if interventions could be meaningfully combined or compared.

Other than conducting subgroup analyses for type of diagnostic/screening tool, delivery methods, and settings of CBT and IPT studies, very little data was available for exploring potential modifiers of treatment effect.

4. Discussion

Many studies included in this review were assessing the potential benefits of nonpharmacologic treatments. We identified few RCTs reporting data on any potential harms or adverse effects associated with nonpharmacologic treatments during the perinatal period. We were unable to expand the scope of the review to look for harms among observational studies. This is an important area for future research.

Studies were inconsistent in full reporting of outcome data. Some studies only reported effect sizes, without reporting on averages, at the end of treatment, only reported positive results in tables and reported negative results in the text, or were missing key outcome data. We only included studies in meta-analysis where full outcome data were available.

4.5 Implications for Clinical and Policy Decision Making

As summarized in Table 28, there is evidence for the effectiveness of nonpharmacologic treatment for perinatal mental health conditions. These findings may lend support to clinical practice guidelines and consensus statements for the use of nonpharmacologic interventions during the perinatal period. Our findings lend the strongest empirical support to CBT and IPT treatments, however this may primarily reflect the large number of RCTs for these treatments. There is evidence that effectiveness of CBT or IPT may not vary by the mode of delivery (i.e. group, individual, or self-guided) or by the delivery setting (in the patient's home, in the clinic, or remotely), indicating there may be flexibility in terms of how such interventions can be delivered while maintaining effectiveness. CBT was an effective treatment for individuals with depressive disorders and combined anxiety and depressive disorders, but not for individuals with depressive or anxiety disorders. Most interventions in this review that aimed to treat combined depressive and anxiety disorders described how the intervention was adapted to be transdiagnostic (addressing both disorders), however such adaptations were not noted in studies testing CBT for depressive or anxiety disorders. These findings suggest that for interventions to be effective across diagnostic groups they must be specifically adapted to be transdiagnostic.

Given the effectiveness of multiple interventions (CBT, IPT, exercise, behavioral activation, and acupuncture) there is a need for a well-trained work force across multiple specialties, included by not limited to obstetrics and gynecology, psychiatry, nursing, and psychology.

The finding of this review suggest that technology could be used to increase access to nonpharmacologic treatments during the perinatal period. For example, many rural and underserved urban areas have limited numbers of providers of mental healthcare who patients can feasibly access.⁹¹ Treatments that could be delivered via telephone or online may help increase access to mental health treatment, although some barriers including access to high-speed internet may remain.

However, the RCT evidence base does not adequately address the comparison between CBT and IPT or the effect or comparative effectiveness of other nonpharmacologic interventions. Evidence for other nonpharmacologic interventions including behavioral activation, bright-light therapy, non-directive counseling and acupuncture is more limited than the evidence supporting CBT and IPT. Future, rigorous trials comparing nonpharmacologic and pharmacologic interventions for perinatal mental health disorders are needed to inform clinical and policy decision making.

4. Discussion

4.6 Implications for Research

We identified multiple areas for further research. Firstly, although it is estimated that approximately 20 percent of perinatal individuals meet criteria for anxiety disorder,² we identified only a limited number of studies testing the comparative effectiveness of nonpharmacologic interventions for this population. Given the high prevalence of anxiety disorders in the perinatal period, and some limited evidence that CBT or IPT is effective for treating anxiety symptoms in individuals with anxiety and depressive disorders, it is crucial that future research addresses this gap in the evidence.

We identified several studies comparing the effectiveness of nonpharmacologic interventions for perinatal individuals with PTSD. However, the heterogeneity in interventions and inconsistent reporting of outcome measures made it challenging to draw evidence-based conclusions. Further, rigorous research is needed on this topic.

Although they are rarer clinical diagnoses, there are similar gaps in the research for perinatal individuals experiencing bipolar disorder or obsessive-compulsive disorder. Future research is needed to confirm whether nonpharmacologic therapies are safe alternative or adjunctive therapies to pharmacologic treatment for these conditions.

The feasibility and effectiveness of different nonpharmacologic treatments may vary by factors including the perinatal period, loss of the infant or infant death, or breast feeding. Both the stressors affecting mothers and the feasibility of implementing different treatments may be different in different peripartum stages and may require different nonpharmacologic approaches. While there was insufficient evidence available in this review, future research is needed to understand which intervention may work best or not work for various socio-demographic groups during the perinatal period. Furthermore, there are significant barriers to accessing mental healthcare during the perinatal period, there is a need to understand how to implement and increase access to nonpharmacologic treatments in different intersectional groups, including by age, race, ethnicity, gender, sexual orientation, geographical location, and partner status.

The effectiveness of nonpharmacologic interventions may also vary by the component “ingredients”. For example, studies may evaluate the effectiveness of CBT but implement different components (e.g. cognitive restructuring or behavioral activation). Conversely, studies may be testing different interventions which share similar components (e.g. keeping a diary or setting goals). Future research is needed to test which interventions components and what combination of components common to nonpharmacologic interventions are likely to be most effective for the different perinatal disorders. By identifying which components are most effective, it might be possible to develop brief interventions while maintaining effectiveness.

Studies included in this review addressed a wide range of outcome domains and measures. There is a need to adopt a core set of outcomes and measures, and standardized approaches to reporting outcomes. We are aware that efforts are underway.^{51, 187} However, it will be essential that once a core outcome set is developed, researchers implement investigation and reporting of these outcomes. It is important to note that this is a growing area of research and numerous trials testing the effectiveness of nonpharmacologic treatments for perinatal mental health conditions are currently underway. As of April 2, 2024, there are 21 active studies registered on [ClincialTrials.gov](https://clinicaltrials.gov) testing nonpharmacologic treatments for perinatal mental health conditions.

4. Discussion

4.7 Conclusions

Although we identified a large number of studies, we are able to make only a few specific conclusions for prioritized outcomes in this review. There is evidence that CBT, IPT, exercise, and behavioral activation are effective treatments for treating depressive symptoms in individuals with perinatal depressive disorders. CBT, IPT and specific-acupuncture were associated with increased remission rates for depressive disorders. However, conclusions regarding remission rates were rated low SoE. There was evidence that CBT and IPT are effective in treating anxiety in perinatal individuals with depressive and anxiety disorders. Additionally, IPT but not CBT was found to be effective in reducing anxiety symptoms in individuals with combined depressive and anxiety disorders. RCTs of nonpharmacologic treatments for PTSD are heterogeneous and did not adequately report results. Thus, we were not able to draw conclusions related to the nonpharmacologic treatment of PTSD. Similarly, RCT evidence on nonpharmacologic treatments for OCD is sparse. There is also only very sparse RCT evidence comparing nonpharmacologic to pharmacologic interventions. While findings are promising regarding the potential effectiveness of nonpharmacologic treatments, we identified numerous areas with no or sparse existing evidence. To guide clinical and policy decision-making, future research is needed to evaluate the comparative effectiveness of lesser studied nonpharmacologic interventions and lesser studied perinatal mental health disorders.

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Abbreviations and Acronyms

AHRQ	Agency for Healthcare Research and Quality
AAI	Adult Attachment Interview
ACOG	American College of Obstetrics and Gynecology
APiA	American Psychiatric Association
APoA	American Psychological Association
BA	Behavioral Activation
BADS	Behavioral Activation for Depression Scale
BAI	Beck Anxiety Inventory
BDI	Beck Depression Inventory
BLT	Bright Light Therapy
BRS	Behavioral Rating Scale
BSQ	Behavioral Screening Questionnaire
CBT	Cognitive Behavioral Therapy
CES-D	Center for Epidemiology Depression Scale
CGI	Clinical Global Impression Scale
CI	Confidence Interval
CINAHL	Cumulative Index to Nursing and Allied Health Literature
COI	Conflict(s) of Interest
COVID	Coronavirus disease 2019
CPG	Clinical Practice Guidelines
CSQ-8	Client Satisfaction Questionnaire
DASS	Depression, Anxiety, Stress Scale
DSM	Diagnostic Statistical Manual
EMDR	Eye Movement Desensitization and Reprocessing Therapy
EPC	Evidence-based Practice Center
EPDS	Edinburgh Postnatal Depression Scale
EQ-5D	EuroQol-5 Dimensions
EROS	Environmental Reward Observation Scale
GAD-7	General Anxiety Disorder 7
GRADE	Grading of Recommendations, Assessment, Development, and Evaluations
HAM-D	Hamilton Depression Rating Scale
ICD	International Classification of Diseases
IPT	Interpersonal Therapy
ISEL	Interpersonal Support Evaluation List
KI	Key Informant(s)
LES-Q	The Quality of Life, Enjoyment, and Satisfaction Questionnaire

MAI	Maternal Attachment Inventory
MCS	Mental Health Component of the SF-12
MEQ	Maternal Efficacy Questionnaire
MFAS	Maternal Fetal Attachment Scale
NICU	Neonatal Intensive Care Unit
OCD	Obsessive-Compulsive Disorder
OCI	Obsessive-Compulsive Inventory
PAI	Prenatal Attachment Inventory
PBCL	Preschool Behavioral Checklist
PBQ	Postpartum Bonding Questionnaire
PCS	Physical Health Component of the SF-12
PHQ-9	Patient Health Questionnaire
PROSPERO	International Prospective Register of Systematic Reviews
PSI	Parenting Stress Index
PSS	Perceived Stress Scale
PTSD	Post-Traumatic Stress Disorder
RCT	Randomized Controlled Trial
RR	Relative Risk
SAS	Social Adjustment Scale
SCID	Structured Clinical Interview for the DSM
SD	Standard Deviation
SF-36	Short-Form Thirty-six-Dimension
SMD	Standardized Mean Difference
SPS	Social Provision Scale
SRDR	Systematic Review Data Repository Plus
SSI	Social Support Interview
SSQR	Social Support Questionnaire Revised
STAI	State Trait Anxiety Inventory
TAU	Treatment as Usual
TEP	Technical Expert Panel
WSAS	Work and Social Adjustment Scale
Y-BOCS	Yale–Brown Obsessive–Compulsive Scale

Appendix A. Methods

A.1 Search Strategies

A.1.1 PubMed Searched 4/20/23

("Breast Feeding"[Mesh] OR "Perinatal Care"[Mesh] OR "Pregnancy"[Mesh] OR "Pregnant Women"[Mesh] OR "pregnancy complications"[Mesh] OR "pregnancy trimesters"[Mesh] OR "Postnatal Care"[Mesh] OR "Perinatal Care"[Mesh] OR "Peripartum Period"[Mesh] OR "Maternal Health Services"[Mesh] OR "fetal growth" OR gestat* OR "gestational age" OR pregnancy OR pregnant OR trimester OR postpartum OR post-partum OR postnatal OR post-natal OR prenatal OR pre-natal OR "pre natal" OR antenatal OR ante-natal OR "ante natal" OR postdelivery OR post-delivery OR "post delivery" OR Peripartum OR Peri-partum OR Peri-natal OR Perinatal OR "fourth trimester" OR "4th trimester" OR matern* OR (traum* AND (birth* OR delivery)) OR abortion OR miscarriage*)

AND

("Anxiety Disorders"[Mesh] OR "Bipolar Disorder"[Mesh] OR "Mood Disorders"[Mesh] OR "Obsessive-Compulsive Disorder"[Mesh] OR "Stress Disorders, Post-Traumatic"[Mesh] OR "Depressive Disorder"[MeSH] OR "Depressive Disorder, Major"[Mesh] OR Depression[Mesh] OR "Mental Health"[Mesh] OR "Mental Disorders"[Mesh] OR "Stress Disorders, Traumatic"[Mesh] OR bipolar OR anxiety OR depress* OR anxiety OR bipolar OR "GAD" OR (mental AND (health OR illness OR disorders)) OR "Obsessive-Compulsive Disorder" OR "OCD" OR "Persistent Depressive Disorder" OR "post-traumatic stress disorder" OR "post-traumatic stress disorders" OR "posttraumatic stress disorder" OR "posttraumatic stress disorders" OR PTSD)

AND

("Psychotherapy"[Mesh] OR "Acupuncture Therapy"[Mesh] OR "Complementary Therapies"[Mesh] OR "Mind-Body Therapies"[Mesh] OR Mindfulness[Mesh] OR Yoga[Mesh] OR "Electroconvulsive Therapy"[Mesh] OR "Sensory Art Therapies"[Mesh] OR "Cognitive behavioral therapy" OR "Cognitive behavioural therapy" OR "Cognitive-behavioral treatment" OR "Cognitive behavioural treatment" OR "CBT" OR "trauma-focused therapy" OR "trauma focused therapy" OR mindfulness OR "cognitive processing therapy" OR cognitive restructuring OR cognitive remediation therapy OR Psychotherapy OR psychodynamic OR ("IPT" NOT insulin) OR "dialectical behavioral therapy" OR "psychodynamic therapy" OR Exposure therapy OR "Narrative Exposure Therapy" OR stress inoculation training OR "Eye movement desensitization and reprocessing therapy" OR "Eye movement desensitisation and reprocessing therapy" OR ECT OR "Acceptance and commitment therapy" OR "Acceptance therapy" OR "Behavioral therapy" OR "Behavioural therapy" OR "Problem-solving therapy" OR "Interpersonal therapy" OR "Imagery rehearsal therapy" OR "Support therapy" OR Psychoeducation OR "Trauma affect regulation" OR "Problem solving therapy" OR electroconvulsive or electroshock OR ((Complementary OR alternative) AND (medic* OR therap*)) OR Relaxation OR Yoga OR Acupuncture OR "Bright light therapy" OR Tai Chi OR "Self-hypnosis and relaxation" OR "Social rhythm therapy" OR "Music therapy" OR "Art therapy" OR "Art therapies" OR "Writing therapy" OR "Writing therapies" OR acupuncture OR supplement OR mind-body OR nondrug OR non-drug OR nonpharmac* OR non-pharmac* OR psychotherap* OR "traditional Chinese" OR "TCM" OR supplement* OR psychoeducation

OR “Culturally Informed” OR “culturally-based intervention” OR “Dual diagnosis therapy” OR “Dual diagnosis treatment” OR “Interpersonal process groups” OR Peer-based OR “peer support”)

AND

("Random Allocation"[Mesh] OR "Clinical Trial" [Publication Type] OR "Double-Blind Method"[Mesh] OR "Single-Blind Method"[Mesh] OR "Placebos"[Mesh] OR random* OR placebo OR ((clinical OR controlled) AND trial*) OR ((singl* OR doubl* OR trebl* OR tripl*) AND (blind* OR mask*)) OR Phase 3 OR Phase III OR RCT OR "Randomized Controlled Trial" [Publication Type] OR systematic[sb])

A.1.2 Cochrane Searched 4/20/23

ID Search Hits

- #1 MeSH descriptor: [Breast Feeding] explode all trees
- #2 MeSH descriptor: [Perinatal Care] explode all trees
- #3 MeSH descriptor: [Pregnancy] explode all trees
- #4 MeSH descriptor: [Pregnant Women] explode all trees
- #5 MeSH descriptor: [Pregnancy Complications] explode all trees
- #6 MeSH descriptor: [Pregnancy Trimesters] explode all trees
- #7 MeSH descriptor: [Postnatal Care] explode all trees
- #8 MeSH descriptor: [Perinatal Care] explode all trees
- #9 MeSH descriptor: [Peripartum Period] explode all trees
- #10 MeSH descriptor: [Maternal Health Services] explode all trees
- #11 “fetal growth” OR gestat* OR “gestational age” OR pregnancy OR pregnant OR trimester OR postpartum OR post-partum OR postnatal OR post-natal OR prenatal OR pre-natal OR “pre natal” OR antenatal OR ante-natal OR “ante natal” OR postdelivery OR post-delivery OR "post delivery" OR Peripartum OR Peri-partum OR Peri-natal OR Perinatal OR "fourth trimester" OR "4th trimester" OR matern* OR (traum* AND (birth* OR delivery)) OR abortion OR miscarriage*
- #12 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11
- #13 MeSH descriptor: [Anxiety Disorders] explode all trees
- #14 MeSH descriptor: [Bipolar Disorder] explode all trees
- #15 MeSH descriptor: [Mood Disorders] explode all trees
- #16 MeSH descriptor: [Obsessive-Compulsive Disorder] explode all trees
- #17 MeSH descriptor: [Stress Disorders, Post-Traumatic] explode all trees
- #18 MeSH descriptor: [Depressive Disorder] explode all trees
- #19 MeSH descriptor: [Depressive Disorder, Major] explode all trees
- #20 MeSH descriptor: [Depression] explode all trees
- #21 MeSH descriptor: [Mental Health] explode all trees
- #22 MeSH descriptor: [Mental Disorders] explode all trees
- #23 MeSH descriptor: [Stress Disorders, Traumatic] explode all trees
- #24 bipolar OR anxiety OR depress* OR anxiety OR bipolar OR “GAD” OR (mental AND (health OR illness OR disorders)) OR "Obsessive-Compulsive Disorder" OR “OCD” OR "Persistent Depressive Disorder" OR "post-traumatic stress disorder" OR "post-traumatic stress disorders" OR "posttraumatic stress disorder" OR "posttraumatic stress disorders" OR PTSD

#25 #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24

#26 MeSH descriptor: [Psychotherapy] explode all trees

#27 MeSH descriptor: [Complementary Therapies] explode all trees

#28 MeSH descriptor: [Mind-Body Therapies] explode all trees

#29 MeSH descriptor: [Mindfulness] explode all trees

#30 MeSH descriptor: [Yoga] explode all trees

#31 Cognitive behavioral therapy OR Cognitive-behavioral therapy OR Cognitive-behavioral treatment OR CBT OR trauma-focused therapy OR trauma focused therapy OR mindfulness OR cognitive processing therapy OR cognitive restructuring OR cognitive remediation therapy OR Psychotherapy OR psychodynamic OR (IPT NOT insulin) OR dialectical behavioral therapy OR psychodynamic therapy OR Exposure therapy OR Narrative Exposure Therapy OR stress inoculation training OR Eye movement desensitization and reprocessing therapy OR ECT OR Acceptance and commitment therapy OR Acceptance therapy OR Behavioral therapy OR Problem-solving therapy OR Interpersonal therapy OR Imagery rehearsal therapy OR Support therapy OR Psychoeducation OR Trauma affect regulation OR Problem solving therapy OR electroconvulsive or electroshock OR ((Complementary OR alternative) AND (medic* OR therap*)) OR Relaxation OR Yoga OR Acupuncture OR Bright light therapy OR Tai Chi OR Self-hypnosis and relaxation OR Social rhythm therapy OR Music therapy OR Art therapy OR Writing therapy OR acupuncture OR supplement OR mind-body OR nondrug OR non-drug OR nonpharmac* OR non-pharmac* OR psychotherap* OR traditional Chinese OR TCM OR supplement* OR psychoeducation OR Culturally Informed OR culturally-based intervention OR Dual diagnosis therapy OR Dual diagnosis treatment OR Interpersonal process groups OR Peer-based OR peer support

#32 MeSH descriptor: [Electroconvulsive Therapy] explode all trees

#33 MeSH descriptor: [Sensory Art Therapies] explode all trees

#34 #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33

#35 #12 AND #25 AND #34

A.1.3 Embase Searched 4/20/23

#59 #32 AND #58

#58 #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47 OR #48 OR #49 OR #50 OR #51 OR #52 OR #53 OR #54 OR #55 OR #56 OR #57

#57 'culturally informed' OR 'culturally-based intervention' OR 'dual diagnosis therapy' OR 'dual diagnosis treatment' OR 'interpersonal process groups'

#56 supplement OR 'mind body' OR nondrug OR 'non drug' OR nonpharmac* OR 'non pharmac*' OR psychotherap* OR 'traditional chinese'

#55 ('music' OR 'art' OR 'writing') AND 'therapy'

#54 'tai chi'

#53 'relaxation training'

#52 (complementary OR alternative) AND (medic* OR therap*)

#51 electroshock

#50 'electric shock'

#49 'psychoeducation'

#48 ('reprocessing' OR 'acceptance' OR 'problem solving' OR 'interpersonal' OR 'imagery rehearsal' OR 'support') AND 'therapy'
 #47 'eye movement desensitization'
 #46 'stress inoculation training'
 #45 'narrative exposure'
 #44 'ipt' NOT insulin
 #43 psychodynamic
 #42 'cognitive' AND ('processing' OR 'behavioural' OR 'remediation') AND 'therapy'
 #41 'mindfulness'
 #40 'trauma focused therapy'
 #39 'cognitive behavioral therapy'
 #38 'electroconvulsive therapy'
 #37 'yoga'
 #36 'mindfulness'
 #35 'alternative medicine'
 #34 'acupuncture'
 #33 'psychotherapy'
 #32 #10 AND #22 AND #31
 #31 #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30
 #30 mental AND (health OR illness OR disorders)
 #29 'mental disease'
 #28 'depression'
 #27 'posttraumatic stress disorder'
 #26 'obsessive compulsive disorder'
 #25 'mood disorder'
 #24 'bipolar disorder'
 #23 'anxiety disorder'
 #22 #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21
 #21 pregnancy OR pregnant OR trimester OR postpartum OR 'post partum' OR postnatal OR 'post natal' OR prenatal OR 'pre natal' OR antenatal OR 'ante natal' OR postdelivery OR 'post delivery' OR peripartum OR 'peri partum' OR 'peri natal' OR perinatal
 #20 'fourth trimester'
 #19 'maternal health service'
 #18 'perinatal period'
 #17 'antenatal care'
 #16 'postnatal care'
 #15 'pregnancy complication'
 #14 'pregnant woman'
 #13 'pregnancy'
 #12 'breast feeding'
 #11 'perinatal care'
 #10
 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9
 #9 'phase 3' OR 'phase iii'
 #8 'phase 3 clinical trial'
 #7 assign* OR allocat* OR volunteer*

#6 singl* AND blind*
 #5 double* AND blind*
 #4 random* OR factorial* OR crossover* OR cross-over* OR placebo*
 #3 'single blind procedure'
 #2 'double blind procedure'
 #1 'randomized controlled trial'/exp OR 'randomized controlled trial'

A.1.4 CINAHL/PsycINFO Searched 4/20/23

(“fetal growth” OR gestat* OR “gestational age” OR pregnancy OR pregnant OR trimester OR postpartum OR post-partum OR postnatal OR post-natal OR prenatal OR pre-natal OR “pre natal” OR antenatal OR ante-natal OR “ante natal” OR postdelivery OR post-delivery OR "post delivery" OR Peripartum OR Peri-partum OR Peri-natal OR Perinatal OR "fourth trimester" OR "4th trimester" OR matern* OR (traum* AND (birth* OR delivery)) OR abortion OR miscarriage*) AND (bipolar OR anxiety OR depress* OR anxiety OR bipolar OR “GAD” OR (mental AND (health OR illness OR disorders)) OR "Obsessive-Compulsive Disorder" OR “OCD” OR "Persistent Depressive Disorder" OR "post-traumatic stress disorder" OR "post-traumatic stress disorders" OR "posttraumatic stress disorder" OR "posttraumatic stress disorders" OR PTSD) AND (Cognitive behavioral therapy OR Cognitive-behavioral therapy OR Cognitive-behavioral treatment OR CBT OR trauma-focused therapy OR trauma focused therapy OR mindfulness OR cognitive processing therapy OR cognitive restructuring OR cognitive remediation therapy OR Psychotherapy OR psychodynamic OR (IPT NOT insulin) OR dialectical behavioral therapy OR psychodynamic therapy OR Exposure therapy OR Narrative Exposure Therapy OR stress inoculation training OR Eye movement desensitization and reprocessing therapy OR ECT OR Acceptance and commitment therapy OR Acceptance therapy OR Behavioral therapy OR Problem-solving therapy OR Interpersonal therapy OR Imagery rehearsal therapy OR Support therapy OR Psychoeducation OR Trauma affect regulation OR Problem solving therapy OR electroconvulsive or electroshock OR ((Complementary OR alternative) AND (medic* OR therap*)) OR Relaxation OR Yoga OR Acupuncture OR Bright light therapy OR Tai Chi OR Self-hypnosis and relaxation OR Social rhythm therapy OR Music therapy OR Art therapy OR Writing therapy OR acupuncture OR supplement OR mind-body OR nondrug OR non-drug OR nonpharmac* OR non-pharmac* OR psychotherap* OR traditional Chinese OR TCM OR supplement* OR psychoeducation OR Culturally Informed OR culturally-based intervention OR Dual diagnosis therapy OR Dual diagnosis treatment OR Interpersonal process groups OR Peer-based OR peer support) AND (meta-analysis OR meta analy* OR metanaly* OR metaanaly* OR met analy* OR (systematic AND (review* OR overview*)) OR ((selection OR inclusion OR exclusion) AND criteria) OR data extraction OR relevant journals OR "Comparative Effectiveness" OR random* OR placebo OR ((clinical OR controlled) AND trial*) OR ((singl* OR doubl* OR trebl* OR tripl*) AND (blind* OR mask*)) OR RCT OR Phase 3 OR Phase III OR "Randomized Controlled Trial" OR systematic review OR meta-analysis)

A.2 Identifying Participants With Mental Health Disorders

If studies have not used a structured diagnostic criteria/diagnostic tool to identify participants with diagnoses of depressive disorders, anxiety disorders, OCD or PTSD (e.g. DSM, SCID, ICD-9, ICD-10, CIS-R, Munich-Composite International Diagnostic Interview, Traumatic Events Scale, The National Institute of Mental Health Diagnostic Interview Schedule), studies must meet the proposed cut-off for at least one of the following validated screening tools to be included.

Cut-offs were identified from previous research. Where possible we used cut-offs recommended by studies that compared the sensitivity, specificity, or positive or negative predictive value of the proposed cut-off with a validated diagnostic tool.

Table A-1 Validated screening tool cut-offs for depressive and anxiety disorders

Disorder	Validated Screening Tool	Proposed Cut-Off	Reference to Support Cut-Off
Depressive disorders	Beck Depression Inventory (BDI)	≥ 12	Milgrom, Jeannette, et al. Screening for postnatal depression in routine primary care: properties of the Edinburgh Postnatal Depression Scale in an Australian sample." Australian & New Zealand Journal of Psychiatry 39.9 (2005): 833-839.
	Center for Epidemiology Depression scale (CES-D)	≥ 16	"The CES-D scale: A self-report depression scale for research in the general population." Applied psychological measurement 1.3 (1977): 385-401.
	Edinburgh Postnatal Depression Scale (EPDS)	≥ 10	Levis, Brooke, et al. "Accuracy of the Edinburgh Postnatal Depression Scale (EPDS) for screening to detect major depression among pregnant and postpartum women: systematic review and meta-analysis of individual participant data." bmj 371 (2020).
	Patient Health Questionnaire (PHQ-9)	≥ 10	Sidebottom, Abbey C., et al. "Validation of the Patient Health Questionnaire (PHQ)-9 for prenatal depression screening." Archives of women's mental health 15 (2012): 367-374.
	Whooley questions/ PHQ-2	Yes	Howard, Louise Michele, et al. "Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy." The British Journal of Psychiatry 212.1 (2018): 50-56.
	Leverton Questionnaire	≥ 12	Csatornai, Sarolta, et al. "Validation of the Leverton Questionnaire as a screening tool for postnatal depression in Hungary." General hospital psychiatry 31.1 (2009): 56-66.
Anxiety disorders	Beck Anxiety Inventory (BAI)	≥ 16	Horwitz, Sarah Mccue, et al. DOES AN INTERVENTION TO REDUCE MATERNAL ANXIETY, DEPRESSION AND TRAUMA ALSO IMPROVE MOTHERS' PERCEPTIONS OF THEIR PRETERM INFANTS' VULNERABILITY?." Infant mental health journal 36.1 (2015): 42-52.
	General Anxiety Disorder (GAD-7)	≥ 7	Zhong, Qiu-Yue, et al. "Diagnostic validity of the generalized anxiety disorder-7 (GAD-7) among pregnant women." PloS one 10.4 (2015): e0125096.
	Hospital Anxiety and Depression (HADS -anxiety subscale)	≥ 11	Meades, Rose, and Susan Ayers. "Anxiety measures validated in perinatal populations: a systematic review." Journal of affective disorders 133.1-2 (2011):
	State Trait Anxiety Inventory (STAI)	≥ 40	Meades, Rose, and Susan Ayers. "Anxiety measures validated in perinatal populations: a systematic review." Journal of affective disorders 133.1-2 (2011): 1-15.
	Hamilton Depression Rating Scale (HAM-D)	≥ 14	Ji, Shuang, et al. "Validity of depression rating scales during pregnancy and the postpartum period: impact of trimester and parity." Journal of psychiatric research 45.2 (2011): 213-219.

A.3 Intervention Coding Taxonomy

Cognitive behavioral (binary: 0=no; 1=yes)

Code YES if:

Intervention described as focusing on changing the participant's thoughts and/or Behaviors (can include information/modules relevant to pregnancy/birth/motherhood)

May be referred to as:

Cognitive behavioral therapy
CBT
Cognitive behavioral counseling
Trauma-focused CBT
Mindfulness-based CBT
CBT with MI engagement

May refer to common CBT techniques/exercises

Code NO if:

- No mention of cognitive behavioral therapy and CBT principles
- Cognitive analytic therapy (CAT)

Interpersonal Psychotherapy (binary: 0=no; 1=yes)

Code YES if:

- Intervention is described as focusing on the participant's interpersonal relationships
- Is described as a derivative/adaptation of IPT or based on IPT principles (e.g. interpersonal counseling)

Code NO if:

- No mention of interpersonal psychotherapy

Psychoeducation (binary: 0=no; 1=yes)

Code YES if

- The intervention is described as psychoeducation, education or general education. Most interventions include some degree of educational content, only code intervention as educational if there is explicit reference to a stand-alone psychoeducation module or intervention.
- Common names may include:
 - Education(al)
 - Psychoeducation(al)
 - Psychosocial education
 - Educational apps

Code No if

- No mention of psychoeducation
- Educational components are described in the context of adapting other manualized interventions (e.g. CBT or IPT) for the perinatal population

Alternative therapies

Yoga/Tai chi (binary: 0=no; 1=yes)

Code YES if:

- Intervention if described as including yoga or tai chi (e.g. moving through poses and breath work)

Code NO if:

- No mention of yoga or tai chi

Acupuncture (binary: 0=no; 1=yes)

Code YES if:

- Intervention is described as including insertion and stimulation of needles. Elements of massage therapy may also be included.

Code No if:

- No mention of acupuncture or needle insertion

Exercise (binary: 0=no; 1=yes)

Code YES if:

- Increasing movement with one specified component of either: duration, intensity, or frequency

Code NO if:

- No description of physical activities

Bright light therapy (binary: 0=no; 1=yes)

Code YES if:

- Intervention is described as including exposure to bright light (typically at a predetermined color temperature) using a bright light box or similar device

Code NO if:

- No mention of bright light therapy

Problem solving therapy (binary: 0=no; 1=yes)

Code YES if:

- Intervention is described as teaching or reinforcing structured skills for identifying and resolving problems

Code NO if:

- No mention of problem solving or problem-solving techniques

Appendix B. Excluded Studies

Table B-1. List of excluded studies with reasons for exclusion

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
1	N/A	Optimizing cognitive and behavioral approaches for perinatal depression: A systematic review and meta-regression analysis	Global Mental Health	Waqas A.; Zafar S. W.; Akhtar P.; Naveed S.; Rahman A.	Design: Systematic review
2	31698704	Music interventions for anxiety in pregnant women: A systematic review and meta-analysis of randomized controlled trials	Journal of Clinical Medicine	Lin C. J.; Chang Y. C.; Chang Y. H.; Hsiao Y. H.; Lin H. H.; Liu S. J.; Chao C. A.; Wang H.; Yeh T. L.	Design: Systematic review
3	N/A	Long term effectiveness of cognitive behavior therapy for treatment of postpartum depression: A systematic review and meta-analysis	Journal of Pakistan Medical Students	Perveen T.; Mahmood S.; Gosadi I.; Mehraj J.; Sheikh S. S.	Design: Systematic review
4	34262468	Exercise During Pregnancy and Prenatal Depression: A Systematic Review and Meta-Analysis	Frontiers in Physiology	Sanchez-Polan M.; Franco E.; Silva-Jose C.; Gil-Ares J.; Perez-Tejero J.; Barakat R.; Refoyo I.	Design: Systematic review
5	N/A	Group treatment of postpartum depression: A systematic review	Archives of Women's Mental Health	Goodman J. H.	Design: Systematic review
6	N/A	Aromatherapy for Postpartum Depression: A Systematic Review and Meta-Analysis	Journal of Family and Reproductive Health	Shamsunisha Y.; Arunesh A.; Pandiaraja M.; Venugopal V.; Poonguzhali S.; Kuppusamy M.	Design: Systematic review
7	30613846	Non-pharmacological interventions to reduce the symptoms of mild to moderate anxiety in pregnant women. A systematic review and narrative synthesis of women's views on the acceptability of and satisfaction with interventions	Archives of Women's Mental Health	Evans K.; Spiby H.; Morrell J. C.	Design: Systematic review
8	34147932	Efficacy of non-invasive brain stimulation in decreasing depression symptoms during the peripartum period: A systematic review	Journal of Reproductive and Infant Psychology	Pacheco F.; Guiomar R.; Brunoni A.; Buhagiar R.; Evagorou O.; Roca-Lecumberri A.; Poleszczyk A.; Lambregtse-Van Den Berg M.; Caparros-Gonzalez R.; Fonseca A.; Osrio A.; Soliman M.; Ganho-Ávila A.	Design: Systematic review
9	34942447	Effect of peer support intervention on perinatal depression: A meta-analysis	General Hospital Psychiatry	Fang Q.; Lin L.; Chen Q.; Yuan Y.; Wang S.; Zhang Y.; Liu T.; Cheng H.; Tian L.	Design: Systematic review
10	36991389	Effectiveness of cognitive behavioural therapy-based interventions for maternal perinatal depression: a systematic review and meta-analysis	BMC Psychiatry	Pettman D.; O'Mahen H.; Blomberg O.; Svanberg A. S.; von Essen L.; Woodford J.	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
11	25960678	Interventions for postnatal depression assessing the mother-infant relationship and child developmental outcomes: A systematic review	International Journal of Women's Health	Tsivos Z. L.; Calam R.; Sanders M. R.; Wittkowski A.	Design: Systematic review
12	32765754	Role of midwife-supported psychotherapy on antenatal depression, anxiety and maternal health: A meta-analysis and literature review	Experimental and Therapeutic Medicine	Han Q.; Guo M.; Ren F.; Duan D.; Xu X.	Design: Systematic review
13	15209173	Intervening to reduce depression after birth: a systematic review of the randomized trials	Int J Technol Assess Health Care	Lumley J.; Austin M. P.; Mitchell C.	Design: Systematic review
14	15367053	Treatment of postpartum depression, part 1: a critical review of biological interventions	J Clin Psychiatry	Dennis C. L.; Stewart D. E.	Design: Systematic review
15	15367054	Treatment of postpartum depression, part 2: a critical review of nonbiological interventions	J Clin Psychiatry	Dennis C. L.	Design: Systematic review
16	17636841	Psychosocial and psychological interventions for treating antenatal depression	Cochrane Database Syst Rev	Dennis C. L.; Ross L. E.; Grigoriadis S.	Design: Systematic review
17	17943888	Psychosocial and psychological interventions for treating postpartum depression	Cochrane Database Syst Rev	Dennis C. L.; Hodnett E.	Design: Systematic review
18	17978316	Effects of treating postnatal depression on mother-infant interaction and child development: systematic review	Br J Psychiatry	Poobalan A. S.; Aucott L. S.; Ross L.; Smith W. C.; Helms P. J.; Williams J. H.	Design: Systematic review
19	18843730	Interventions (other than pharmacological, psychosocial or psychological) for treating antenatal depression	Cochrane Database Syst Rev	Dennis C. L.; Allen K.	Design: Systematic review
20	19126829	The effectiveness of exercise in the management of post-natal depression: systematic review and meta-analysis	Fam Pract	Daley A.; Jolly K.; MacArthur C.	Design: Systematic review
21	19137448	A systematic review of home-based interventions to prevent and treat postpartum depression	Arch Womens Ment Health	Leis J. A.; Mendelson T.; Tandon S. D.; Perry D. F.	Design: Systematic review
22	19445768	Postnatal depression	BMJ Clin Evid	Craig M.; Howard L.	Design: Systematic review
23	20653342	Management of post traumatic stress disorder after childbirth: a review	J Psychosom Obstet Gynaecol	Lapp L. K.; Agbokou C.; Peretti C. S.; Ferreri F.	Design: Systematic review
24	20863477	Group cognitive behavioural therapy for postnatal depression: a systematic review of clinical effectiveness, cost-effectiveness and value of information analyses	Health Technol Assess	Stevenson M. D.; Scope A.; Sutcliffe P. A.; Booth A.; Slade P.; Parry G.; Saxon D.; Kalthenthaler E.	Design: Systematic review
25	21545782	A meta-analysis of treatments for perinatal depression	Clin Psychol Rev	Sockol L. E.; Epperson C. N.; Barber J. P.	Design: Systematic review
26	21720793	Group treatment for postpartum depression: a systematic review	Arch Womens Ment Health	Goodman J. H.; Santangelo G.	Design: Systematic review
27	21735413	Mind-body interventions during pregnancy for preventing or treating women's anxiety	Cochrane Database Syst Rev	Marc I.; Toureche N.; Ernst E.; Hodnett E. D.; Blanchet C.; Dodin S.; Njoya M. M.	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
28	23904069	Interventions (other than pharmacological, psychosocial or psychological) for treating antenatal depression	Cochrane Database Syst Rev	Dennis C. L.; Dowswell T.	Design: Systematic review
29	24240636	Efficacy of systemically oriented psychotherapies in the treatment of perinatal depression: a meta-analysis	Arch Womens Ment Health	Claridge A. M.	Design: Systematic review
30	24283266	Is group cognitive behaviour therapy for postnatal depression evidence-based practice? A systematic review	BMC Psychiatry	Scope A.; Leaviss J.; Kaltenthaler E.; Parry G.; Sutcliffe P.; Bradburn M.; Cantrell A.	Design: Systematic review
31	24957781	Interpersonal psychotherapy for postpartum depression: a systematic review	Arch Womens Ment Health	Miniati M.; Callari A.; Calugi S.; Rucci P.; Savino M.; Mauri M.; Dell'Osso L.	Design: Systematic review
32	25238209	A systematic review of perinatal depression interventions for adolescent mothers	J Adolesc	Lieberman K.; Le H. N.; Perry D. F.	Design: Systematic review
33	25522839	The effects of psychological treatment of maternal depression on children and parental functioning: a meta-analysis	Eur Child Adolesc Psychiatry	Cuijpers P.; Weitz E.; Karyotaki E.; Garber J.; Andersson G.	Design: Systematic review
34	25652267	Yoga for prenatal depression: a systematic review and meta-analysis	BMC Psychiatry	Gong H.; Ni C.; Shen X.; Wu T.; Jiang C.	Design: Systematic review
35	25743368	A systematic review of the efficacy of cognitive behavioral therapy for treating and preventing perinatal depression	J Affect Disord	Sockol L. E.	Design: Systematic review
36	26346905	Mindfulness and perinatal mental health: A systematic review	Women Birth	Hall H. G.; Beattie J.; Lau R.; East C.; Anne Biro M.	Design: Systematic review
37	27621164	Effectiveness of Psychological Interventions for Postnatal Depression in Primary Care: A Meta-Analysis	Ann Fam Med	Stephens S.; Ford E.; Paudyal P.; Smith H.	Design: Systematic review
38	28358808	Interventions to treat mental disorders during pregnancy: A systematic review and multiple treatment meta-analysis	PLoS One	van Ravesteyn L. M.; Lambregtse-van den Berg M. P.; Hoogendijk W. J.; Kamperman A. M.	Design: Systematic review
39	28702773	Can exercise or physical activity help improve postnatal depression and weight loss? A systematic review	Arch Womens Ment Health	Saligheh M.; Hackett D.; Boyce P.; Cobley S.	Design: Systematic review
40	28757900	The Effectiveness of Mindfulness-Based Interventions on Maternal Perinatal Mental Health Outcomes: a Systematic Review	Mindfulness (N Y)	Shi Z.; MacBeth A.	Design: Systematic review
41	28962068	The effect of perinatal depression treatment for mothers on parenting and child development: A systematic review	Depress Anxiety	Letourneau N. L.; Dennis C. L.; Cosic N.; Linder J.	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
42	29201244	Mindfulness-Based Interventions During Pregnancy: a Systematic Review and Meta-analysis	Mindfulness (N Y)	Dhillon A.; Sparkes E.; Duarte R. V.	Design: Systematic review
43	29368048	A systematic review of psychological treatments for clinical anxiety during the perinatal period	Arch Womens Ment Health	Loughnan S. A.; Wallace M.; Joubert A. E.; Haskelberg H.; Andrews G.; Newby J. M.	Design: Systematic review
44	29616334	Effectiveness of self-help psychological interventions for treating and preventing postpartum depression: a meta-analysis	Arch Womens Ment Health	Lin P. Z.; Xue J. M.; Yang B.; Li M.; Cao F. L.	Design: Systematic review
45	29882074	The effectiveness of exercise-based interventions for preventing or treating postpartum depression: a systematic review and meta-analysis	Arch Womens Ment Health	Carter T.; Bastounis A.; Guo B.; Jane Morrell C.	Design: Systematic review
46	29902211	Clinical effectiveness of family therapeutic interventions in the prevention and treatment of perinatal depression: A systematic review and meta-analysis	PLoS One	Cluxton-Keller F.; Bruce M. L.	Design: Systematic review
47	29907576	Effectiveness of acupuncture in postpartum depression: a systematic review and meta-analysis	Acupunct Med	Li S.; Zhong W.; Peng W.; Jiang G.	Design: Systematic review
48	29935979	Treatment of depression, anxiety, and trauma-related disorders during the perinatal period: A systematic review	Clin Psychol Rev	Nilini Y. I.; Mehralizade A.; Mayer L.; Milanovic S.	Design: Systematic review
49	30068424	Opening windows of opportunities: Evidence for interventions to prevent or treat depression in pregnant women being associated with changes in offspring's developmental trajectories of psychopathology risk	Dev Psychopathol	Goodman S. H.; Cullum K. A.; Dimidjian S.; River L. M.; Kim C. Y.	Design: Systematic review
50	30313002	Antidepressant Treatment of Depression During Pregnancy and the Postpartum Period	Evid Rep Technol Assess (Full Rep)	McDonagh M.; Matthews A.; Phillipi C.; Romm J.; Peterson K.; Thakurta S.; Guise J. M.	Design: Systematic review
51	30321198	Is cognitive behavioral therapy a better choice for women with postnatal depression? A systematic review and meta-analysis	PLoS One	Huang L.; Zhao Y.; Qiang C.; Fan B.	Design: Systematic review
52	30343660	The effectiveness of telemedicine interventions to address maternal depression: A systematic review and meta-analysis	J Telemed Telecare	Nair U.; Armfield N. R.; Chatfield M. D.; Edirippulige S.	Design: Systematic review
53	30388545	The efficacy of cognitive behavior therapy for the treatment of perinatal anxiety symptoms: A preliminary meta-analysis	J Anxiety Disord	Maguire P. N.; Clark G. I.; Wootton B. M.	Design: Systematic review
54	30396632	A systematic review of acupuncture and Chinese herbal medicine for postpartum depression	Complement Ther Clin Pract	Yang L.; Di Y. M.; Shergis J. L.; Li Y.; Zhang A. L.; Lu C.; Guo X.; Xue C. C.	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
55	30423471	The effect of complementary medicines and therapies on maternal anxiety and depression in pregnancy: A systematic review and meta-analysis	J Affect Disord	Smith C. A.; Shewamene Z.; Galbally M.; Schmied V.; Dahlen H.	Design: Systematic review
56	30428883	Offspring outcomes after prenatal interventions for common mental disorders: a meta-analysis	BMC Med	Brouwer M. E.; Williams A. D.; van Grinsven S. E.; Cuijpers P.; Lambregtse-van den Berg M. P.; Burger H.; Bockting C. L. H.	Design: Systematic review
57	30515108	Effectiveness of Trauma-Focused Psychological Therapies for Treating Post-traumatic Stress Disorder Symptoms in Women Following Childbirth: A Systematic Review and Meta-Analysis	Front Psychiatry	Furuta M.; Horsch A.; Ng E. S. W.; Bick D.; Spain D.; Sin J.	Design: Systematic review
58	30688418	Effectiveness of eHealth Interventions to Reduce Perinatal Anxiety: A Systematic Review and Meta-Analysis	J Clin Psychiatry	Bayrampour H.; Trieu J.; Tharmaratnam T.	Design: Systematic review
59	30712750	A meta-analysis of the effectiveness of yoga-based interventions for maternal depression during pregnancy	Complement Ther Clin Pract	Ng Q. X.; Venkatanarayanan N.; Loke W.; Yeo W. S.; Lim D. Y.; Chan H. W.; Sim W. S.	Design: Systematic review
60	31057080	The efficiency of online cognitive-behavioral therapy for postpartum depressive symptomatology: a systematic review and meta-analysis	Women Health	Roman M.; Constantin T.; Bostan C. M.	Design: Systematic review
61	31101993	Internet-delivered psychological interventions for clinical anxiety and depression in perinatal women: a systematic review and meta-analysis	Arch Womens Ment Health	Loughnan S. A.; Joubert A. E.; Grierson A.; Andrews G.; Newby J. M.	Design: Systematic review
62	31129438	A systematic review of the safety and effectiveness of repetitive transcranial magnetic stimulation in the treatment of peripartum depression	J Psychiatr Res	Cole J.; Bright K.; Gagnon L.; McGirr A.	Design: Systematic review
63	31164035	Treatment of posttraumatic stress disorder following childbirth	J Psychosom Obstet Gynaecol	de Bruijn L.; Stramrood C. A.; Lambregtse-van den Berg M. P.; Rius Ottenheim N.	Design: Systematic review
64	31196691	Efficacy of rTMS in decreasing postnatal depression symptoms: A systematic review	Psychiatry Res	Ganho-Avila A.; Poleszczyk A.; Mohamed M. M. A.; Osorio A.	Design: Systematic review
65	31259837	Traditional Chinese acupuncture and postpartum depression: A systematic review and meta-analysis	J Chin Med Assoc	Tong P.; Dong L. P.; Yang Y.; Shi Y. H.; Sun T.; Bo P.	Design: Systematic review
66	31541788	The effectiveness of music therapy for postpartum depression: A systematic review and meta-analysis	Complement Ther Clin Pract	Yang W. J.; Bai Y. M.; Qin L.; Xu X. L.; Bao K. F.; Xiao J. L.; Ding G. W.	Design: Systematic review

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67	31550613	The short- and long-term effectiveness of mother-infant psychotherapy on postpartum depression: A systematic review and meta-analysis	J Affect Disord	Huang R.; Yang D.; Lei B.; Yan C.; Tian Y.; Huang X.; Lei J.	Design: Systematic review
68	31619096	The effect of cognitive-behavioral therapy on psychological distress in the mothers of preterm infants: a systematic review and meta-analysis	J Psychosom Obstet Gynaecol	Seiiedi-Biarag L.; Mirghafourvand M.; Ghanbari-Homayi S.	Design: Systematic review
69	31928569	Effects of parenting interventions for mothers with depressive symptoms and an infant: systematic review and meta-analysis	BJPsych Open	Rayce S. B.; Rasmussen I. S.; Vaever M. S.; Pontoppidan M.	Design: Systematic review
70	32553366	A systematic review of non-invasive neurostimulation for the treatment of depression during pregnancy'	J Affect Disord	Konstantinou G. N.; Vigod S. N.; Mehta S.; Daskalakis Z. J.; Blumberger D. M.	Design: Systematic review
71	32553392	The efficacy of cognitive behavioral therapy for the treatment of antenatal depression: A systematic review	J Affect Disord	Shortis E.; Warrington D.; Whittaker P.	Design: Systematic review
72	32563204	Effectiveness of cognitive behavioural therapy for perinatal depression: A systematic review and meta-analysis	J Clin Nurs	Li Z.; Liu Y.; Wang J.; Liu J.; Zhang C.	Design: Systematic review
73	32629701	Role of psychotherapy on antenatal depression, anxiety, and maternal quality of life: A meta-analysis	Medicine (Baltimore)	Li C.; Sun X.; Li Q.; Sun Q.; Wu B.; Duan D.	Design: Systematic review
74	32738663	Effectiveness of peer support intervention on perinatal depression: A systematic review and meta-analysis	J Affect Disord	Huang R.; Yan C.; Tian Y.; Lei B.; Yang D.; Liu D.; Lei J.	Design: Systematic review
75	33358645	The contribution of group prenatal care to maternal psychological health outcomes: A systematic review	Women Birth	Buultjens M.; Farouque A.; Karimi L.; Whitby L.; Milgrom J.; Erbas B.	Design: Systematic review
76	33563220	Repetitive transcranial magnetic stimulation treatment for peripartum depression: systematic review & meta-analysis	BMC Pregnancy Childbirth	Lee H. J.; Kim S. M.; Kwon J. Y.	Design: Systematic review
77	33637070	Psychological interventions for maternal depression among women of African and Caribbean origin: a systematic review	BMC Womens Health	Jidong D. E.; Husain N.; Roche A.; Lourie G.; Ike T. J.; Murshed M.; Park M. S.; Karick H.; Dagona Z. K.; Pwajok J. Y.; Gumber A.; Francis C.; Nyam P. P.; Mwankon S. B.	Design: Systematic review
78	34062397	Effectiveness of psychological interventions in the treatment of perinatal depression: A systematic review of systematic reviews and meta-analyses	J Affect Disord	Branquinho M.; Rodriguez-Munoz M. F.; Maia B. R.; Marques M.; Matos M.; Osma J.; Moreno-Peral P.; Conejo-Ceron S.; Fonseca A.; Voursora E.	Design: Systematic review

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79	34464836	Non-pharmacological interventions to reduce anxiety in pregnancy, labour and postpartum: A systematic review	Midwifery	Dominguez-Solis E.; Lima-Serrano M.; Lima-Rodriguez J. S.	Design: Systematic review
80	34714882	Mobile interventions targeting common mental disorders among pregnant and postpartum women: An equity-focused systematic review	PLoS One	Saad A.; Magwood O.; Aubry T.; Alkhateeb Q.; Hashmi S. S.; Hakim J.; Ford L.; Kassam A.; Tugwell P.; Pottie K.	Design: Systematic review
81	34749125	The effectiveness of psychological interventions for pregnant women with anxiety in the antenatal period: A systematic review	Midwifery	Callanan F.; Tuohy T.; Bright A. M.; Grealish A.	Design: Systematic review
82	34849370	A Systematic Review and Meta-analysis of the Effects of Music Therapy on Postpartum Anxiety and Pain Levels	J Caring Sci	Hakimi S.; Hajizadeh K.; Hasanzade R.; Ranjbar M.	Design: Systematic review
83	34943246	Effects of Exercise during Pregnancy on Postpartum Depression: A Systematic Review of Meta-Analyses	Biology (Basel)	Marconcin P.; Peralta M.; Gouveia E R.; Ferrari G.; Carraca E.; Ihle A.; Marques A.	Design: Systematic review
84	35123346	Effectiveness of cognitive behavioral therapy for perinatal maternal depression, anxiety and stress: A systematic review and meta-analysis of randomized controlled trials	Clin Psychol Rev	Li X.; Laplante D. P.; Paquin V.; Lafortune S.; Elgbeili G.; King S.	Design: Systematic review
85	35166688	Remotely Delivered Interventions to Support Women With Symptoms of Anxiety in Pregnancy: Mixed Methods Systematic Review and Meta-analysis	J Med Internet Res	Evans K.; Rennick-Egglestone S.; Cox S.; Kuipers Y.; Spiby H.	Design: Systematic review
86	35188471	eHealth Interventions for Treatment and Prevention of Depression, Anxiety, and Insomnia During Pregnancy: Systematic Review and Meta-analysis	JMIR Ment Health	Silang K. A.; Sohal P. R.; Bright K. S.; Leason J.; Roos L.; Lebel C.; Giesbrecht G. F.; Tomfohr-Madsen L. M.	Design: Systematic review
87	35257692	Effect of mindfulness-based interventions on mental health of perinatal women with or without current mental health issues: A systematic review and meta-analysis of randomized controlled trials	J Affect Disord	Yan H.; Wu Y.; Li H.	Design: Systematic review
88	35286442	Exercise and yoga during pregnancy and their impact on depression: a systematic literature review	Arch Womens Ment Health	Jarbou N. S.; Newell K. A.	Design: Systematic review
89	35514260	Resilience-enhancing interventions for antepartum depressive symptoms: systematic review	BJPsych Open	Walker A. L.; Witteveen A. B.; Otten R. H. J.; Verhoeven C. J.; Henrichs J.; de Jonge A.	Design: Systematic review
90	35564762	Efficacy of Prenatal Yoga in the Treatment of Depression and Anxiety during Pregnancy: A Systematic Review and Meta-Analysis	Int J Environ Res Public Health	Lin I. H.; Huang C. Y.; Chou S. H.; Shih C. L.	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
91	35772128	Yoga's Therapeutic Effect on Perinatal Depression: A Systematic Review and Meta-Analysis	Psychiatr Danub	Wang G.; Liang C.; Sun G.	Design: Systematic review
92	35887812	Efficacy and Safety of Transcranial Electric Stimulation during the Perinatal Period: A Systematic Literature Review and Three Case Reports	J Clin Med	Laurin A.; Nard N.; Dalmont M.; Bulteau S.; Benard C.; Bonnot O.; Winer N.; Dupont F.; Apter G.; Terranova-Commessie F.; Guillin O.; El-Hage W.; Sauvaget A.; Rotharmel M.	Design: Systematic review
93	36186359	Effect of mindfulness meditation on depression during pregnancy: A meta-analysis	Front Psychol	Li Y.; Chen J.; Chen B.; Wang T.; Wu Z.; Huang X.; Li S.	Design: Systematic review
94	36423436	Internet-delivered mindfulness-based interventions for mental health outcomes among perinatal women: A systematic review	Asian J Psychiatr	Mao F.; Sun Y.; Li Y.; Cui N.; Cao F.	Design: Systematic review
95	36504355	The effectiveness of psychological interventions for anxiety in the perinatal period: A systematic review and meta-analysis	Psychol Psychother	Clinkscales N.; Golds L.; Berlouis K.; MacBeth A.	Design: Systematic review
96	36707743	Systematic Review of Online Interventions to Reduce Perinatal Mood and Anxiety Disorders in Underserved Populations	J Perinat Neonatal Nurs	Canfield S. M.; Canada K. E.	Design: Systematic review
97	36729324	Black with 'Baby Blues': A Systematic Scoping Review of Programs to Address Postpartum Depression in African American Women	Matern Child Health J	Robertson K.; Wells R.	Design: Systematic review
98	36841089	Mindfulness-based intervention for clinical and subthreshold perinatal depression and anxiety: A systematic review and meta-analysis of randomized controlled trial	Compr Psychiatry	Leng L. L.; Yin X. C.; Ng S. M.	Design: Systematic review
99	36963518	The effect of mindfulness-based interventions during pregnancy on postpartum mental health: A meta-analysis	J Affect Disord	Min W.; Jiang C.; Li Z.; Wang Z.	Design: Systematic review
100	37000462	Efficacy of nondrug interventions in perinatal depression: A meta-analysis	Psychiatry Res	Jiang X.; Li H.; Wang D.; Shan L.; Wang F.; Kang Y.	Design: Systematic review
101	37029894	Psychodynamic Psychotherapy for Postpartum Depression: A Systematic Review	Matern Child Health J	Valverde N.; Mollejo E.; Legarra L.; Gomez-Gutierrez M.	Design: Systematic review
102	26336787	Yoga for prenatal depression: a systematic review and meta-analysis'	Pract Midwife	Regan M	Design: Systematic review
103	25535930	Effects of Yoga Intervention during Pregnancy: A Review for Current Status	American Journal of Perinatology	Qinxian Jiang; Zhengguo Wu; Li Zhou; Dunlop Jenae; Peijie Chen	Design: Systematic review
104	25896571	Efficacy, Feasibility, and Acceptability of Perinatal Yoga on Women's Mental Health and Well-Being	Journal of Holistic Nursing	Sheffield Karen M.; Woods-Giscombe Cheryl L.	Design: Systematic review

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105	27118000	An evaluation of perinatal mental health interventions: An integrative literature review	Women & Birth	Lavender Theresa J.; Ebert Lyn; Jones Donovan	Design: Systematic review
106	N/A	Acupuncture versus antidepressants in the management of postpartum depression: A systematic review	British Journal of Midwifery	Komori Akari; Arthur David; Radford Samara; Tan Hsiewe Ying; Zheng Li; An Mira; Umeda Rika; Zheng Zhen	Design: Systematic review
107	N/A	Treating Depression During Pregnancy and the Postpartum: A Preliminary Meta-Analysis	Research on Social Work Practice	Bledsoe Sarah E.; Grote Nancy K.	Design: Systematic review
108	18161036	Psychological treatment of postpartum depression: A meta-analysis	Journal of Clinical Psychology	Cuijpers Pim; Brannmark Jessica G.; van Straten Annemieke	Design: Systematic review
109	N/A	A Systematic Literature Review of Nursing Interventions for Postpartum Depression and their Outcomes	Philippine Journal of Nursing	Peñalba AFNM; Cabrera PNC; Camagong KD; Pagatpatan CP	Design: Systematic review
110	N/A	Efficacy and safety of acupuncture for postpartum depression: A systematic review	Chinese Journal of Evidence-Based Medicine	Cao Y.; Cao W.; Yuan J.; Li M.; Li X.; Yang K.; Wen C.	Design: Systematic review
111	20653342	Management of post traumatic stress disorder after childbirth: A review	Journal of Psychosomatic Obstetrics & Gynecology	Lapp Leann K.; Agbokou Catherine; Peretti Charles-Siegfried; Ferreri Florian	Design: Systematic review
112	28076639	Transcranial magnetic stimulation for treatment of major depression during pregnancy: A review	Trends in Psychiatry and Psychotherapy	Felipe Renata de Melo; Ferrao Ygor Arzeno	Design: Systematic review
113	N/A	Complementary health approaches for postpartum depression: A systematic review	Social Work in Mental Health	McCloskey Rebecca J.; Reno Rebecca	Design: Systematic review
114	34774299	Effect of digital cognitive behavioral therapy on psychological symptoms among perinatal women in high income-countries: A systematic review and meta-regression	Journal of Psychiatric Research	Lau Ying; Yen Kai Yoong; Wong Sai Ho; Cheng Jing Ying; Cheng Ling Jie	Design: Systematic review
115	N/A	Contributing factors, protective elements, and treatments for postpartum PTSD: A systematic review	California Southern University ProQuest Dissertation & Theses	Stelter Mary Pinkerton	Design: Systematic review

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116	35838293	Clinical practice guidelines with recommendations for peripartum depression: A European systematic review	Acta Psychiatrica Scandinavica	Motrico Emma; Moreno-Peral Patricia; Uriko Kristiina; Hancheva Camellia; Brekalo Maja; Ajaz Erilda; Apter Gisele; Bramante Alessandra; Conejo-Ceron Sonia; Christoforou Andri; Dikmen-Yildiz Pelin; Evagorou Olympia; Fonseca Ana; Lupattelli Angela; Rados Sandra Nakic; al Maach Nadia; Rodriguez-Munoz Marja F.; Lambregtse - van den Berg Mijke P.	Design: Systematic review
117	33580709	Antidepressant treatment for postnatal depression	Cochrane Database of Systematic Reviews	Brown J. V.; Wilson C. A.; Ayre K.; Robertson L.; South E.; Molyneaux E.; Trevillion K.; Howard L. M.; Khalifeh H.	Design: Systematic review
118	N/A	Parent-infant psychotherapy for improving parental and infant mental health	Cochrane Database of Systematic Reviews	Barlow J.; Bennett C.; Midgley N.; Larkin S. K.; Wei Y.	Design: Systematic review
119	32827841	The effectiveness of massage for reducing pregnant women's anxiety and depression; systematic review and meta-analysis	Midwifery	Hall H. G.; Cant R.; Munk N.; Carr B.; Tremayne A.; Weller C.; Fogarty S.; Lauche R.	Design: Systematic review
120	29783936	Identifying and assessing the benefits of interventions for postnatal depression: A systematic review of economic evaluations	BMC Pregnancy and Childbirth	Gurung B.; Jackson L. J.; Monahan M.; Butterworth R.; Roberts T. E.	Design: Systematic review
121	25929986	Postpartum electroconvulsive therapy: a systematic review and case report	Gen Hosp Psychiatry	Gressier F.; Rotenberg S.; Cazas O.; Hardy P.	Design: Systematic review
122	28486363	Effects of Exercise on Mild-to-Moderate Depressive Symptoms in the Postpartum Period: A Meta-analysis	Obstet Gynecol	McCurdy A. P.; Boule N. G.; Sivak A.; Davenport M. H.	Design: Systematic review
123	33340151	Psychological Intervention and Treatment for Posttraumatic Stress Disorder During Pregnancy: A Systematic Review and Call to Action	J Trauma Stress	Stevens N. R.; Miller M. L.; Puetz A. K.; Padin A. C.; Adams N.; Meyer D. J.	Design: Systematic review
124	33533904	Implementation and Effectiveness of Nonspecialist-Delivered Interventions for Perinatal Mental Health in High-Income Countries: A Systematic Review and Meta-analysis	JAMA Psychiatry	Singla D. R.; Lawson A.; Kohrt B. A.; Jung J. W.; Meng Z.; Ratjen C.; Zahedi N.; Dennis C. L.; Patel V.	Design: Systematic review
125	34818326	Early psychological interventions for prevention and treatment of post-traumatic stress disorder (PTSD) and post-traumatic stress symptoms in post-partum women: A systematic review and meta-analysis	PLoS One	Taylor Miller P. G.; Sinclair M.; Gillen P.; McCullough J. E. M.; Miller P. W.; Farrell D. P.; Slater P. F.; Shapiro E.; Klaus P.	Design: Systematic review

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126	N/A	Healthcare interventions for perinatal depression in socially disadvantaged women: A systematic review and meta-analysis	Clinical Psychology: Science and Practice	Rojas-Garcia Antonio; Ruiz-Perez Isabel; Goncalves Daniela C.; Rodriguez-Barranco Miguel; Ricci-Cabello Ignacio	Design: Systematic review
127	21439042	Mums 4 Mums: Structured telephone peer-support for women experiencing postnatal depression. Pilot and exploratory RCT of its clinical and cost effectiveness	Trials	Caramlau I.; Barlow J.; Sembi S.; McKenzie-McHarg K.; McCabe C.	Other...
128	31538488	Effectiveness of a peer support intervention for antenatal depression: a feasibility study	Journal of Reproductive and Infant Psychology	Carter R.; Cust F.; Boath E.	Other...
129	N/A	Transcranial magnetic stimulation for the treatment of major depression during pregnancy: Efficacy and safety of a novel therapeutical strategy	European Neuropsychopharmacology	Arzeno Ferrao Y.; Silva R.; Lieberknecht R.	Not full report (eg, conference abstract)
130	34231203	Interventions for fear of childbirth including tocophobia	Cochrane Database of Systematic Reviews	O'Connell M. A.; Khashan A. S.; Leahy-Warren P.; Stewart F.; O'Neill S. M.	P: Not disorder of interest
131	N/A	Psychosocial and psychological interventions for treating postpartum depression: An updated Cochrane systematic review	Archives of Women's Mental Health	Dennis C. L.; Vigod S. N.; Brown H. K.	Not full report (eg, conference abstract)
132	33247023	Mental health of Urban Mothers (MUM) study: A multicentre randomised controlled trial, study protocol	BMJ Open	Schwank S. E.; Chung H. F.; Hsu M.; Fu S. C.; Du L.; Zhu L.; Huang H. Y.; Andersson E.; Acharya G.	Other...
133	N/A	State of the art and future perspectives on the use of non-invasive neuromodulation in peripartum psychiatric disorders	Encephale	Poleszczyk A.; Kosinska-Kaczynska K.; Avila A. G.; Palm U.; Pereira A. T.; Andrade J.	Not full report (eg, conference abstract)
134	N/A	Early vs. Late wake therapy improves mood in antepartum vs. Postpartum depression by differentially altering melatonin and sleep timing	Sleep	Parry B. L.; Meliska C.; Lopez A.; Sorenson D.; Martinez F.; Orff H.; Hauger R.; Kripke D.	Not full report (eg, conference abstract)
135	N/A	The PRogram in Support of Moms (PRISM): Results of A Cluster Randomized Controlled Trial of Two Active Interventions Addressing Perinatal Depression in Ambulatory Obstetric Settings	Journal of the Academy of Consultation-Liaison Psychiatry	Byatt N.; Brenckle L.; Sankaran P.; Flahive J.; Ko J.; Robbins C. L.; Zimmermann M.; Allison J.; Person S. D.; Simas T. M.	Not full report (eg, conference abstract)
136	8970662	Massage and relaxation therapies' effects on depressed adolescent mothers	Adolescence	Field T.; Grizzle N.; Scafidi F.; Schanberg S.	Not publication year ≥ 2000
137	9099116	A controlled study of fluoxetine and cognitive-behavioural counselling in the treatment of postnatal depression	Bmj	Appleby L.; Warner R.; Whitton A.; Faragher B.	Not publication year ≥ 2000
138	11686971	Caregiver support for postpartum depression	Cochrane Database Syst Rev	Ray K. L.; Hodnett E. D.	Other...

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
139	12655910	The effect of peer support on postpartum depression: a pilot randomized controlled trial	Can J Psychiatry	Dennis C. L.	Duplicate/Secondary analysis (no new data)
140	15973255	A randomized controlled trial of the effects of applied relaxation training on reducing anxiety and perceived stress in pregnant women	J Midwifery Womens Health	Bastani F.; Hidarnia A.; Kazemnejad A.; Vafaei M.; Kashanian M.	S: Not high-income country
141	16420094	Reexamining paroxetine and cognitive-behavioral therapy in postpartum depression and anxiety	J Clin Psychiatry	McClendon J.	D: Not primary study
142	18086500	Postnatal depression and mother and infant outcomes after infant massage	J Affect Disord	O'Higgins M.; St James Roberts I.; Glover V.	I: No intervention of interest
143	19962699	Postpartum depression peer support: maternal perceptions from a randomized controlled trial	Int J Nurs Stud	Dennis C. L.	Other...
144	20361919	Treatment effects of massage therapy in depressed people: a meta-analysis	J Clin Psychiatry	Hou W. H.; Chiang P. T.; Hsu T. Y.; Chiu S. Y.; Yen Y. C.	P: Not population of interest (Not perinatal/Not postpartum)
145	20936338	An open trial of in-home CBT for depressed mothers in home visitation	Matern Child Health J	Ammerman R. T.; Putnam F. W.; Stevens J.; Bosse N. R.; Short J. A.; Bodley A. L.; Van Ginkel J. B.	D: Not RCT
146	21128087	Interventions for the prevention and treatment of postpartum psychosis: a systematic review	Arch Womens Ment Health	Doucet S.; Jones I.; Letourneau N.; Dennis C. L.; Blackmore E. R.	P: Not disorder of interest
147	21153559	An interpersonally based intervention for low-income pregnant women with intimate partner violence: a pilot study	Arch Womens Ment Health	Zlotnick C.; Capezza N. M.; Parker D.	P: Not population of interest (Not perinatal/Not postpartum)
148	21349585	Attitudes and adjustment to the parental role in mothers following treatment for postnatal depression	J Affect Disord	Wan M. W.; Sharp D. J.; Howard L. M.; Abel K. M.	D: Not RCT
149	21439042	Mums 4 Mums: structured telephone peer-support for women experiencing postnatal depression. Pilot and exploratory RCT of its clinical and cost effectiveness	Trials	Caramlau I.; Barlow J.; Sembi S.; McKenzie-McHarg K.; McCabe C.	Duplicate/Secondary analysis (no new data)
150	22401479	The effect of sertraline add-on to brief dynamic psychotherapy for the treatment of postpartum depression: a randomized, double-blind, placebo-controlled study	J Clin Psychiatry	Bloch M.; Meiboom H.; Lorberblatt M.; Bluvstein I.; Aharonov I.; Schreiber S.	I: No intervention of interest
151	22789792	The effects of clinical aromatherapy for anxiety and depression in the high risk postpartum woman - a pilot study	Complement Ther Clin Pract	Conrad P.; Adams C.	Not N ≥10/group

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
152	23177594	A review assessing the current treatment strategies for postnatal psychological morbidity with a focus on post-traumatic stress disorder	Midwifery	Peeler S.; Chung M. C.; Stedmon J.; Skirton H.	P: Not population of interest (Not perinatal/Not postpartum)
153	23855406	The effect of physician-based cognitive behavioural therapy among pregnant women with depressive symptomatology: a pilot quasi-experimental trial	Early Interv Psychiatry	McGregor M.; Coghlan M.; Dennis C. L.	D: Not RCT
154	24604461	Cognitive behavioral therapy in combination with systemic family therapy improves mild to moderate postpartum depression	Braz J Psychiatry	Hou Y.; Hu P.; Zhang Y.; Lu Q.; Wang D.; Yin L.; Chen Y.; Zou X.	S: Not high-income country
155	24788589	Effects of antenatal yoga on maternal anxiety and depression: a randomized controlled trial	Depress Anxiety	Newham J. J.; Wittkowski A.; Hurley J.; Aplin J. D.; Westwood M.	P: Not disorder of interest
156	25074561	Pilot early intervention antenatal group program for pregnant women with anxiety and depression	Arch Womens Ment Health	Thomas N.; Komiti A.; Judd F.	D: Not RCT
157	25277158	Early intervention to protect the mother-infant relationship following postnatal depression: study protocol for a randomised controlled trial	Trials	Milgrom J.; Holt C.	Other...
158	25496615	A randomized controlled trial of the effectiveness of a postnatal psychoeducation programme on self-efficacy, social support and postnatal depression among primiparas	J Adv Nurs	Shorey S.; Chan S. W.; Chong Y. S.; He H. G.	P: Not disorder of interest
159	26385456	A pilot randomized controlled trial comparing prenatal yoga to perinatal health education for antenatal depression	Arch Womens Ment Health	Uebelacker L. A.; Battle C. L.; Sutton K. A.; Magee S. R.; Miller I. W.	Not N ≥10/group
160	26518597	Effects of a midwife psycho-education intervention to reduce childbirth fear on women's birth outcomes and postpartum psychological wellbeing	BMC Pregnancy Childbirth	Fenwick J.; Toohill J.; Gamble J.; Creedy D. K.; Buist A.; Turkstra E.; Sneddon A.; Scuffham P. A.; Ryding E. L.	P: Not disorder of interest
161	26595300	THE EFFECTS OF EXPRESSIVE WRITING ON POSTPARTUM DEPRESSION AND POSTTRAUMATIC STRESS SYMPTOMS	Psychol Rep	Blasio P. D.; Camisasca E.; Caravita S. C.; Ionio C.; Milani L.; Valtolina G. G.	P: Not disorder of interest
162	26887958	Evaluation of an antenatal acupuncture intervention as an adjunct therapy for antenatal depression (AcuAnteDep): study protocol for a pragmatic randomised controlled trial	Trials	Ormsby S. M.; Smith C. A.; Dahlen H. G.; Hay P. J.; Lind J. M.	D: Not primary study
163	26991368	Computer- or web-based interventions for perinatal mental health: A systematic review	J Affect Disord	Ashford M. T.; Olander E. K.; Ayers S.	P: Not population of interest (Not perinatal/Not postpartum)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
164	27238068	Brief Psychotherapy for Maternal Depression: Impact on Mothers and Children	J Am Acad Child Adolesc Psychiatry	Swartz H. A.; Cyranowski J. M.; Cheng Y.; Zuckoff A.; Brent D. A.; Markowitz J. C.; Martin S.; Amole M. C.; Ritchey F.; Frank E.	P: Not population of interest (Not perinatal/Not postpartum)
165	27627126	Effects of relaxation on depression levels in women with high-risk pregnancies: a randomised clinical trial	Rev Lat Am Enfermagem	Arajo W. S.; Romero W. G.; Zandonade E.; Amorim M. H.	P: Not disorder of interest
166	27900745	[The Effects of a Mobile Application Social Support Program on Postpartum Perceived Stress and Depression]	Hu Li Za Zhi	Cheng H. Y.; Huang T. Y.; Chien L. Y.; Cheng Y. F.; Chen F. J.	D: Not RCT
167	28223373	NICU-based Interventions To Reduce Maternal Depressive and Anxiety Symptoms: A Meta-analysis	Pediatrics	Mendelson T.; Cluxton-Keller F.; Vullo G. C.; Tandon S. D.; Noazin S.	P: Not disorder of interest
168	28287802	Depressive symptoms and gestational length among pregnant adolescents: Cluster randomized control trial of CenteringPregnancy- π E plus group prenatal care	J Consult Clin Psychol	Felder J. N.; Epel E.; Lewis J. B.; Cunningham S. D.; Tobin J. N.; Rising S. S.; Thomas M.; Ickovics J. R.	P: Not disorder of interest
169	28455276	Therapist-Supported Internet-Based Cognitive Behavior Therapy for Stress, Anxiety, and Depressive Symptoms Among Postpartum Women: A Systematic Review and Meta-Analysis	J Med Internet Res	Lau Y.; Htun T. P.; Wong S. N.; Tam W. S. W.; Klainin-Yobas P.	P: Not disorder of interest
170	28721461	Influence of adjuvant detached mindfulness and stress management training compared to pharmacologic treatment in primiparae with postpartum depression	Arch Womens Ment Health	Ahmadpanah M.; Nazaribadie M.; Aghaei E.; Ghaleiha A.; Bakhtiari A.; Haghighi M.; Bahmani D. S.; Akhondi A.; Bajoghli H.; Jahangard L.; Holsboer-Trachsler E.; Brand S.	S: Not high-income country
171	28745912	Impact of Psychological Grief Counseling on the Severity of Post-Traumatic Stress Symptoms in Mothers after Stillbirths	Issues Ment Health Nurs	Navidian A.; Saravani Z.; Shakiba M.	S: Not high-income country
172	28750631	Music interventions to reduce stress and anxiety in pregnancy: a systematic review and meta-analysis	BMC Psychiatry	Corbijn van Willenswaard K.; Lynn F.; McNeill J.; McQueen K.; Dennis C. L.; Lobel M.; Alderdice F.	P: Not disorder of interest
173	28855163	Does aerobic exercise reduce postpartum depressive symptoms? a systematic review and meta-analysis	Br J Gen Pract	Pritchett R. V.; Daley A. J.; Jolly K.	P: Not disorder of interest

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
174	28950157	Group-based multicomponent treatment to reduce depressive symptoms in women with co-morbid psychiatric and psychosocial problems during pregnancy: A randomized controlled trial	J Affect Disord	Van Ravesteyn L. M.; Kamperman A. M.; Schneider T. A. J.; Raats M. E.; Steegers E. A. P.; Tiemeier H.; Hoogendijk W. J. G.; Lambregtse-van den Berg M. P.	P: Not disorder of interest
175	28964735	Voluntary running influences the efficacy of fluoxetine in a model of postpartum depression	Neuropharmacology	Gobinath A. R.; Richardson R. J.; Chow C.; Workman J. L.; Lieblich S. E.; Barr A. M.; Galea L. A. M.	I: No intervention of interest
176	28987245	The Effect of Relaxation on Mother's Anxiety and Maternal-Fetal Attachment in Primiparous IVF Mothers	J Natl Med Assoc	Toosi M.; Akbarzadeh M.; Ghaemi Z.	P: Not disorder of interest
177	29357918	Internet-based cognitive behavioural therapy (iCBT) for perinatal anxiety and depression versus treatment as usual: study protocol for two randomised controlled trials	Trials	Loughnan S. A.; Newby J. M.; Haskelberg H.; Mahoney A.; Kladnitski N.; Smith J.; Black E.; Holt C.; Milgrom J.; Austin M. P.; Andrews G.	Not full report (eg, conference abstract)
178	29473698	A proof-of-concept pilot randomized comparative trial of brief Internet-based compassionate mind training and cognitive-behavioral therapy for perinatal and intending to become pregnant women	Clin Psychol Psychother	Kelman A. R.; Evare B. S.; Barrera A. Z.; Munoz R. F.; Gilbert P.	P: Not population of interest (Not perinatal/Not postpartum)
179	29501991	A systematic review and meta-analysis of interpersonal psychotherapy for perinatal women	J Affect Disord	Sockol L. E.	P: Not population of interest (Not perinatal/Not postpartum)
180	29914574	Cognitive-Behavioural therapy and interpersonal psychotherapy for the treatment of post-natal depression: a narrative review	BMC Psychol	Stamou G.; Garcia-Palacios A.; Botella C.	D: Not RCT
181	30303063	Maternal antenatal mood and child development: an exploratory study of treatment effects on child outcomes up to 5 years	J Dev Orig Health Dis	Milgrom J.; Holt C. J.; Bleker L. S.; Holt C.; Ross J.; Ericksen J.; Glover V.; O'Donnell K. J.; de Rooij S. R.; Gemmill A. W.	D: Not primary study
182	30455965	Gender-informed psycho-educational programme to promote respectful relationships and reduce postpartum common mental disorders among primiparous women: long-term follow-up of participants in a community-based cluster randomised controlled trial	Glob Ment Health (Camb)	Fisher J.; Tran T.; Wynter K.; Hiscock H.; Bayer J.; Rowe H.	P: Not population of interest (Not perinatal/Not postpartum)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
183	30717815	Exploring the effect of antenatal depression treatment on children's epigenetic profiles: findings from a pilot randomized controlled trial	Clin Epigenetics	Bleker L. S.; Milgrom J.; Sexton-Oates A.; Roseboom T. J.; Gemmill A. W.; Holt C. J.; Saffery R.; Burger H.; de Rooij S. R.	O: No outcome of interest
184	30982086	Effectiveness of mindfulness-based cognitive therapy for comorbid depression and anxiety in pregnancy: a randomized controlled trial	Arch Womens Ment Health	Zemestani M.; Fazeli Nikoo Z.	S: Not high-income country
185	31199291	Optional Web-Based Videoconferencing Added to Office-Based Care for Women Receiving Psychotherapy During the Postpartum Period: Pilot Randomized Controlled Trial	J Med Internet Res	Yang R.; Vigod S. N.; Hensel J. M.	P: Not disorder of interest
186	31246645	The Effects of Aromatherapy on Postpartum Women: A Systematic Review	J Nurs Res	Tsai S. S.; Wang H. H.; Chou F. H.	P: Not disorder of interest
187	31257092	Transcranial direct current stimulation (tDCS) for depression in pregnancy: A pilot randomized controlled trial	Brain Stimul	Vigod S. N.; Murphy K. E.; Dennis C. L.; Oberlander T. F.; Ray J. G.; Daskalakis Z. J.; Blumberger D. M.	Not N ≥ 10 /group
188	31868776	Preventing Postpartum Depression With Mindful Self-Compassion Intervention: A Randomized Control Study	J Nerv Ment Dis	Guo L.; Zhang J.; Mu L.; Ye Z.	P: Not disorder of interest
189	31960525	Psychological interventions for depression and anxiety in pregnant Latina and Black women in the United States: A systematic review	Clin Psychol Psychother	Ponting C.; Mahrer N. E.; Zelcer H.; Dunkel Schetter C.; Chavira D. A.	P: Not disorder of interest
190	32056815	Effects of yoga on anxiety and depression for high risk mothers on hospital bedrest	Complement Ther Clin Pract	Gallagher A.; Kring D.; Whitley T.	P: Not disorder of interest
191	32116849	Cognitive Behavioral Therapy for Antenatal Depression in a Pilot Randomized Controlled Trial and Effects on Neurobiological, Behavioral and Cognitive Outcomes in Offspring 3-7 Years Postpartum: A Perspective Article on Study Findings, Limitations and Future Aims	Front Psychiatry	Bleker L. S.; Milgrom J.; Sexton-Oates A.; Parker D.; Roseboom T. J.; Gemmill A. W.; Holt C. J.; Saffery R.; Connelly A.; Burger H.; de Rooij S. R.	D: Not primary study
192	32315889	Effects of expressive writing intervention for women's PTSD, depression, anxiety and stress related to pregnancy: A meta-analysis of randomized controlled trials	Psychiatry Res	Qian J.; Zhou X.; Sun X.; Wu M.; Sun S.; Yu X.	P: Not disorder of interest
193	32336122	Psychological or educational eHealth interventions on depression, anxiety or stress following preterm birth: a systematic review	J Reprod Infant Psychol	Feng Y. Y.; Korale-Liyanage S.; Jarde A.; McDonald S. D.	P: Not disorder of interest

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
194	32833477	Protocol for a mechanistic study of mindfulness based cognitive therapy during pregnancy	Health Psychol	Mackiewicz Seghete K. L.; Graham A. M.; Lapidus J. A.; Jackson E. L. A.; Doyle O. J.; Feryn A. B.; Moore L. A.; Goodman S. H.; Dimidjian S.	Not full report (eg, conference abstract)
195	33029304	The effects of PTSD treatment during pregnancy: systematic review and case study	Eur J Psychotraumatol	Baas M. A. M.; van Pampus M. G.; Braam L.; Stramrood C. A. I.; de Jongh A.	P: Not population of interest (Not perinatal/Not postpartum)
196	33180001	A spiritual intervention to reduce stress, anxiety and depression in pregnant women: Randomized controlled trial	Health Care Women Int	Sanaeinasab H.; Saffari M.; Sheykh-Oliya Z.; Khalaji K.; Laluie A.; Al Zaben F.; Koenig H. G.	S: Not high-income country
197	33220947	A systematic review of clinical effectiveness of psychological interventions to reduce post traumatic stress symptoms following childbirth and a meta-synthesis of facilitators and barriers to uptake of psychological care	J Affect Disord	Slade P. P.; Molyneux D. R.; Watt D. A.	P: Not disorder of interest
198	33630532	Feasibility, Acceptability, and Preliminary Effects of 'Mindful Moms': A Mindful Physical Activity Intervention for Pregnant Women with Depression	Nurs Res	Kinser P. A.; Thacker L. R.; Rider A.; Moyer S.; Amstadter A. B.; Mazzeo S. E.; Bodnar-Deren S.; Starkweather A.	D: Not RCT
199	33879065	Internet-based behavioural activation to improve depressive symptoms and prevent child abuse in postnatal women (SmartMama): a protocol for a pragmatic randomized controlled trial	BMC Pregnancy Childbirth	Obikane E.; Baba T.; Shinozaki T.; Obata S.; Nakanishi S.; Murata C.; Ushio E.; Suzuki Y.; Shirakawa N.; Honda M.; Sasaki N.; Nishi D.; O'Mahen H.; Kawakami N.	D: Not primary study
200	34147932	Efficacy of non-invasive brain stimulation in decreasing depression symptoms during the peripartum period: A systematic review	J Psychiatr Res	Pacheco F.; Guiomar R.; Brunoni A. R.; Buhagiar R.; Evagorou O.; Roca-Lecumberri A.; Poleszczyk A.; Lambregtse-van den Berg M.; Caparros-Gonzalez R. A.; Fonseca A.; Osorio A.; Soliman M.; Ganho-Avila A.	Duplicate/Secondary analysis (no new data)
201	34147972	The effect of music, massage, yoga and exercise on antenatal depression: A meta-analysis	J Affect Disord	Zhu Y.; Wang R.; Tang X.; Li Q.; Xu G.; Zhang A.	P: Not disorder of interest
202	34322621	The influence of mindfulness-based stress reduction (MBSR) on stress, anxiety and depression due to unwanted pregnancy: a randomized clinical trial	J Prev Med Hyg	Nejad F. K.; Shahraki K. A.; Nejad P. S.; Moghaddam N. K.; Jahani Y.; Divsalar P.	P: Not disorder of interest

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
203	34332359	Advancing health through research: A scoping review of and model for adjunctive psychosocial interventions to improve outcomes for perinatal women with bipolar disorder	J Affect Disord	Friedman R.; Giampaolo J.; Vanhaecke L.; Jarrett R. B.	Other...
204	34488847	Postpartum Early EMDR therapy Intervention (PERCEIVE) study for women after a traumatic birth experience: study protocol for a randomized controlled trial	Trials	Hendrix Ymga; van Dongen K. S. M.; de Jongh A.; van Pampus M. G.	D: Not primary study
205	34758210	Peer-Delivered Cognitive-Behavioral Therapy for Postpartum Depression: A Randomized Controlled Trial	J Clin Psychiatry	Amani B.; Merza D.; Savoy C.; Streiner D.; Bieling P.; Ferro M. A.; Van Lieshout R. J.	Duplicate/Secondary analysis (no new data)
206	34867528	Does One Treatment Fit All? Effectiveness of a Multicomponent Cognitive Behavioral Therapy Program in Data-Driven Subtypes of Perinatal Depression	Front Psychiatry	Waqas A.; Rahman A.	S: Not high-income country
207	34894877	Effectiveness of Psychological Interventions to Improve the Mental Well-Being of Parents Who Have Experienced Traumatic Childbirth: A Systematic Review and Meta-Analysis	Trauma Violence Abuse	Shorey S.; Downe S.; Chua J. Y. X.; Byrne S. O.; Fobelets M.; Lalor J. G.	P: Not disorder of interest
208	34914418	Cognitive behavioral stress management effects on prenatal anxiety among low-income women	J Consult Clin Psychol	Ponting C.; Chavira D. A.; Dunkel Schetter C.; Urizar G. G.	P: Not disorder of interest
209	34936270	[Observation on clinical effect of acupuncture combined with wheat-grain moxibustion for mild to moderate postpartum depression]	Zhongguo Zhen Jiu	Lin Y. Y.; Su S. Y.; Lin X. Y.; Jiang F. X.; Xu Y. Y.; Pan S. N.; Zhang X.; Cai H. Q.	S: Not high-income country
210	35112497	Effectiveness of aromatherapy for intrapartum and postpartum emotional problems among parturient women: A meta-analysis of randomized controlled trials	Jpn J Nurs Sci	Hu T. M.; Lee S. H.; Loh E. W.	P: Not disorder of interest
211	35195532	Digitalized Cognitive Behavioral Interventions for Depressive Symptoms During Pregnancy: Systematic Review	J Med Internet Res	Wan Mohd Yunus W. M. A.; Matinolli H. M.; Waris O.; Upadhyaya S.; Vuori M.; Korpilahti-Leino T.; Ristkari T.; Koffert T.; Sourander A.	P: Not disorder of interest
212	35367919	Internet-delivered psychological interventions for reducing depressive, anxiety symptoms and fear of childbirth in pregnant women: A meta-analysis and meta-regression	J Psychosom Res	Neo H. S.; Tan J. H.; Ang W. H. D.; Lau Y.	P: Not disorder of interest
213	35413533	Emphasizing mindfulness training in acceptance relieves anxiety and depression during pregnancy	Psychiatry Res	Yang M.; Zhou X.; Ye C.; Li J.; Sun S.; Yu X.	S: Not high-income country

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
214	35440458	Protocol for the Healing After Loss (HeAL) Study: a randomised controlled trial of interpersonal psychotherapy (IPT) for major depression following perinatal loss	BMJ Open	Johnson J. E.; Price A. B.; Sikorskii A.; Key K. D.; Taylor B.; Lamphere S.; Huff C.; Cinader M.; Zlotnick C.	Not full report (eg, conference abstract)
215	35699314	Cognitive behavioral therapy in perinatal mental health: An overview of systematic reviews	Jpn J Nurs Sci	Okatsau A.; Aoyama S.; Yamaji N.; Kataoka Y.	P: Not disorder of interest
216	35876837	Sustained remission from perinatal depression after bright light therapy: A pilot randomised, placebo-controlled trial	Acta Psychiatr Scand	Garbazza C.; Cirignotta F.; D'Agostino A.; Cicolin A.; Hackethal S.; Wirz-Justice A.; Cajochen C.; Manconi M.	P: Not disorder of interest
217	35910879	Reliability of Evidence to Guide Decision-Making in the Use of Acupuncture for Postpartum Depression	Front Public Health	Hu X.; Fan Q.; Ma L.; Jin R.; Gong R.; Zhao X.; Qiu F.; Zhou L.	S: Not high-income country
218	36049141	Smartphone-assisted online brief cognitive behavioral therapy to treat maternal depression: findings of a randomized controlled trial	Braz J Psychiatry	Fatori D.; Zuccolo P.; Xavier M. O.; Matijasevich A.; Polanczyk G. V.	S: Not high-income country
219	36189185	The Impact of a Mindfulness App on Postnatal Distress	Mindfulness (N Y)	Bear K. A.; Barber C. C.; Medvedev O. N.	P: Not disorder of interest
220	36276421	Interventions to improve social support among postpartum mothers: A systematic review	Health Promot Perspect	Sharifipour F.; Javadnoori M.; Behboodi Moghadam Z.; Najafian M.; Cheraghian B.; Abbaspoor Z.	P: Not disorder of interest
221	36327004	The impact of maternal depression on child mental health treatment and models for integrating care: a systematic review	Arch Womens Ment Health	Engelhard C.; Hishinuma E.; Rehuher D.	P: Not population of interest (Not perinatal/Not postpartum)
222	36478339	Culturally adapted psychological intervention for treating maternal depression in British mothers of African and Caribbean origin: A randomized controlled feasibility trial	Clin Psychol Psychother	Jidong D. E.; Ike J. T.; Husain N.; Murshed M.; Francis C.; Mwankon B. S.; Jack B. D.; Jidong J. E.; Pwajok Y. J.; Nyam P. P.; Kiran T.; Bassett P.	P: Not population of interest (Not perinatal/Not postpartum)
223	36586616	Critically-timed sleep and light interventions differentially improve mood in pregnancy vs. postpartum depression by shifting melatonin rhythms	J Affect Disord	Parry B. L.; Meliska C. J.; Sorenson D. L.; Martinez L. F.; Lopez A. M.; Dawes S. E.; Elliott J. A.; Hauger R. L.	Other...
224	36871401	Systematic review and meta-analysis of psychoeducation on the psychological and social impact among first-time mothers	Patient Educ Couns	Ong Q. O.; Ong J. W.; Ang M. Q.; Vehvilainen-Julkunen K.; He H. G.	P: Not population of interest (Not perinatal/Not postpartum)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
225	36873226	Art-based interventions for women's mental health in pregnancy and postpartum: A meta-analysis of randomised controlled trials	Front Psychiatry	Qian J.; Sun S.; Wang M.; Sun X.; Yu X.	P: Not population of interest (Not perinatal/Not postpartum)
226	36991389	Effectiveness of cognitive behavioural therapy-based interventions for maternal perinatal depression: a systematic review and meta-analysis	BMC Psychiatry	Pettman D.; O'Mahen H.; Blomberg O.; Svanberg A. S.; von Essen L.; Woodford J.	Duplicate/Second ary analysis (no new data)
227	36997966	Effect of Remote Peer-Counsellor- delivered Behavioral Activation and Peer-support for Antenatal Depression on Gestational Age at Delivery: a single-blind, randomized control trial	Trials	Chaput K. H.; Freeman M.; McMorris C.; Metcalfe A.; Cameron E. E.; Jung J.; Tough S.; Hicks L. M.; Dimidjian S.; Tomfohr-Madsen L. M.	Other...
228	25369906	Depression improvement and parenting in low-income mothers in home visiting	Archives of Women's Mental Health	Ammerman Robert; Altaye Mekibib; Putnam Frank; Teeters Angelique; Zou Yuanshu; Ginkel Judith	Duplicate/Second ary analysis (no new data)
229	24598825	Feasibility and efficacy of an internet treatment for postnatal depression utilising a behavioural activation approach	Evidence Based Nursing	Milgrom Jeannette; Gemmill Alan	Not full report (eg, conference abstract)
230	22789792	The effects of clinical aromatherapy for anxiety and depression in the high risk postpartum woman ,Äi A pilot study	Complementary Therapies in Clinical Practice	Conrad Pam; Adams Cindy	Duplicate/Second ary analysis (no new data)
231	22532053	Trajectories of long-term outcomes for postnatally depressed mothers treated with group interpersonal psychotherapy	Archives of Women's Mental Health	Reay Rebecca; Owen Cathy; Shadbolt Bruce; Raphael Beverley; Mulcahy Rhiannon; Wilkinson Ross	Duplicate/Second ary analysis (no new data)
232	21720793	Group treatment for postpartum depression: a systematic review	Archives of Women's Mental Health	Goodman Janice; Santangelo Gabrielle	Duplicate/Second ary analysis (no new data)
233	20860888	A pragmatic randomised controlled trial to compare antidepressants with a community-based psychosocial intervention for the treatment of women with postnatal depression: the RESPOND trial	Health Technology Assessment	Sharp Dj; Chew-Graham C.; Tylee A.; Lewis G.; Howard L.; Anderson I.; Abel K.; Turner K.; Hollinghurst S.; Tallon D.; McCarthy A.; Peters T.	Duplicate/Second ary analysis (no new data)
234	19633250	Telephone based peer support can reduce postnatal depression in women at high risk	Evidence-based Mental Health	Matthey S.	Not full report (eg, conference abstract)
235	19633251	Training health visitors to identify and treat depressive symptoms with psychological approaches reduces postnatal depression	Evidence-based Mental Health	Dennis C.	Not full report (eg, conference abstract)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
236	19697094	A randomised control [sic] trial for the effectiveness of group interpersonal psychotherapy for postnatal depression	Archives of Women's Mental Health	Mulcahy R.; Reay R. E.; Wilkinson R. B.; Owen C.	Duplicate/Secondary analysis (no new data)
237	19962699	Postpartum depression peer support: maternal perceptions from a randomized controlled trial	International Journal of Nursing Studies	Dennis C.	Duplicate/Secondary analysis (no new data)
238	23904069	Interventions (other than pharmacological, psychosocial or psychological) for treating antenatal depression	Cochrane Database of Systematic Reviews	Dennis C.; Dowswell T.	Duplicate/Secondary analysis (no new data)
239	18669682	Six-month multicomponent intervention improves postnatal depression in low-income settings	Evidence-based Mental Health	Zayas L. H.	Not full report (eg, conference abstract)
240	18669681	Review: psychosocial and psychological interventions reduce postpartum depressive symptoms	Evidence-based Mental Health	Abel K. M.	Not full report (eg, conference abstract)
241	17636841	Psychosocial and psychological interventions for treating antenatal depression	Cochrane Database of Systematic Reviews	Dennis C.; Ross L. E.; Grigoriadis S.	Duplicate/Secondary analysis (no new data)
242	17943888	Psychosocial and psychological interventions for treating postpartum depression	Cochrane Database of Systematic Reviews	Dennis C.; Hodnett E. D.	Duplicate/Secondary analysis (no new data)
243	16638899	Counselling and cognitive behavioural therapy reduce anxiety and depression in women with postnatal depression	Evidence-based Mental Health	Dennis C.	Not full report (eg, conference abstract)
244	25062520	Early Intervention in Pregnant Women With Elevated Anxiety and Depressive Symptoms	Journal of Perinatal & Neonatal Nursing	Bittner Antje; Peukert Judith; Zimmermann Cornelia; Junge-Hoffmeister Juliane; Parker Lisa S.; Stobel-Richter Yve; Weidner Kerstin	Duplicate/Secondary analysis (no new data)
245	25804297	A pragmatic randomized controlled trial to evaluate the effectiveness of a facilitated exercise intervention as a treatment for postnatal depression: the PAMPeRS trial	Psychological Medicine	Daley A. J.; Blamey R. V.; Jolly K.; Roalfe A. K.; Turner K. M.; Coleman S.; McGuinness M.; Jones I.; Sharp D. J.; MacArthur C.	Duplicate/Secondary analysis (no new data)
246	111864890. Language:	Postnatal. A systematic review of psychosocial interventions for women with postpartum stress	MIDIRS Midwifery Digest	Ju-Eun Song; Kim Tiffany; Ahn Jeong-Ah	P: Not population of interest (Not perinatal/Not postpartum)
247	27003141	Interpersonal psychotherapy (IPT) for major depression following perinatal loss: a pilot randomized controlled trial	Archives of Women's Mental Health	Johnson Jennifer; Price Ann; Kao Jennifer; Fernandes Karen; Stout Robert; Gobin Robyn; Zlotnick Caron	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
248	28855163	Does aerobic exercise reduce postpartum depressive symptoms? A systematic review and meta-analysis	MIDIRS Midwifery Digest	Pritchett Ruth Victoria; Daley Amanda J.; Jolly Kate	Duplicate/Secondary analysis (no new data)
249	N/A	Effectiveness of acupuncture as an add-on treatment for women with postnatal depression: a systematic review	Women & Birth	Wang Carol; Bayes Sara	Not full report (eg, conference abstract)
250	31246645	The Effects of Aromatherapy on Postpartum Women: A Systematic Review	Journal of Nursing Research (Lippincott Williams & Wilkins)	Tsai Shuo-Shin; Wang Hsiu-Hung; Chou Fan-Hao	Duplicate/Secondary analysis (no new data)
251	32629701	Role of psychotherapy on antenatal depression, anxiety, and maternal quality of life: A meta-analysis	Medicine	Caixia Li; Xiaohua Sun; Qing Li; Qian Sun; Beibei Wu; Dongyun Duan; Li Caixia; Sun Xiaohua; Li Qing; Sun Qian; Wu Beibei; Duan Dongyun	Duplicate/Secondary analysis (no new data)
252	34749125	The effectiveness of psychological interventions for pregnant women with anxiety in the antenatal period: A systematic review	Midwifery	Callanan Fiona; Tuohy Teresa; Bright Ann-Marie; Grealish Annmarie	Duplicate/Secondary analysis (no new data)
253	N/A	Mindfulness- and Compassion-Based Parenting Interventions Applied to the Postpartum Period: A Systematic Review	Journal of Child & Family Studies	Fernandes Daniela V.; Martins Ana R.; Canavarro Maria C.; Moreira Helena	P: Not population of interest (Not perinatal/Not postpartum)
254	35195532	Digitalized Cognitive Behavioral Interventions for Depressive Symptoms During Pregnancy: Systematic Review	Journal of Medical Internet Research	Yunus Wan Mohd Azam Wan Mohd; Matinolli Hanna-Maria; Waris Otto; Upadhyaya Subina; Vuori Miika; Korpilahti-Leino Tarja; Ristkari Terja; Koffert Tarja; Sourander Andre; Wan Mohd Yunus Wan Mohd Azam	Duplicate/Secondary analysis (no new data)
255	33706830	Unexpected effects of expressive writing on post-disaster distress in the Hurricane Harvey Study: a randomized controlled trial in perinatal women	Psychological Medicine	Paquin Vincent; Bick Johanna; Lipschutz Rebecca; Elgbeili Guillaume; Laplante David P.; Biekman Brian; Brunet Alain; King Suzanne; Olson David	Duplicate/Secondary analysis (no new data)
256	12724244	Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression 1 Impact on maternal mood	The British Journal of Psychiatry	Cooper Peter J.; Murray Lynne; Wilson Anji; Romaniuk Helena	Duplicate/Secondary analysis (no new data)
257	12724245	Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression 2 Impact on the mother--child relationship and child outcome	The British Journal of Psychiatry	Murray Lynne; Cooper Peter J.; Wilson Anji; Romaniuk Helena	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
258	N/A	Prevention and treatment of post partum depression: A controlled study	Devenir	Chabrol Henri; Teissedre Frederique; Saint-Jean Michele; Teisseyre Nathalie; Roge Bernadette	Duplicate/Secondary analysis (no new data)
259	15367052	The Use of Paroxetine and Cognitive-Behavioral Therapy in Postpartum Depression and Anxiety: A Randomized Controlled Trial	The Journal of Clinical Psychiatry	Misri Shaila; Reebye Pratibha; Corral Maria; Mills Lisa	Duplicate/Secondary analysis (no new data)
260	N/A	A Controlled Clinical Trial of Citalopram and Citalopram Combined with Psychotherapy in the Treatment of Postpartum Depression	Chinese Mental Health Journal	Chun-Liu Qiu; Bo Xiao; Wen-Jiao Xie	S: Not high-income country
261	28636219	A mother-infant therapy group model for postpartum depression	Infant Mental Health Journal	Clark Roseanne; Tluczek Audrey; Brown Roger	D: Not RCT
262	N/A	A physician-based Cognitive Behavioral Intervention for depressed pregnant women in primary care: A pilot study		McGregor Marla Louise	D: Not RCT
263	21535997	A randomized, double-blind, placebo-controlled study of light therapy for antepartum depression	The Journal of Clinical Psychiatry	Wirz-Justice Anna; Bader Anja; Frisch Ulrike; Stieglitz Rolf-Dieter; Alder Judith; Bitzer Johannes; Hosli Irene; Jazbec Sandra; Benedetti Francesco; Terman Michael; Wisner Katherine L.; Riecher-Rossler Anita	Duplicate/Secondary analysis (no new data)
264	22840621	Randomized non-invasive sham-controlled pilot trial of electroacupuncture for postpartum depression	Journal of Affective Disorders	Chung Ka-Fai; Yeung Wing-Fai; Zhang Zhang-Jin; Yung Kam-Ping; Man Sui-Cheung; Lee Chin-Peng; Lam Siu-Keung; Leung Tsin-Wah; Leung Kwok-Yin; Ziea Eric Tat-Chi; Wong Vivian Taam	Duplicate/Secondary analysis (no new data)
265	23602514	Internet-based behavioral activation treatment for postnatal depression (Netmums): A randomized controlled trial	Journal of Affective Disorders	O'Mahen Heather A.; Woodford Joanne; McGinley Julia; Warren Fiona C.; Richards David A.; Lynch Thomas R.; Taylor Rod S.	Duplicate/Secondary analysis (no new data)
266	25074561	Pilot early intervention antenatal group program for pregnant women with anxiety and depression': Erratum	Archives of Women's Mental Health	Thomas Naomi; Komiti Angela; Judd Fiona	Duplicate/Secondary analysis (no new data)
267	N/A	The feasibility of yoga in the treatment of antenatal depression and anxiety: A pilot study	Doctoral dissertation, Thesis Master	Davis Kyle J.	Other...

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
268	25886805	Efficacy of yoga for depressed postpartum women: A randomized controlled trial	Complement Ther Clin Pract	Buttner Melissa Mercedes	Duplicate/Secondary analysis (no new data)
269	26261095	Performance of a culturally tailored cognitive behavioral intervention integrated in a public health setting to reduce risk of antepartum depression: A randomized controlled trial	Journal of Midwifery & Women's Health	Jesse D. Elizabeth; Gaynes Bradley N.; Feldhousen Elizabeth B.; Newton Edward R.; Bunch Shelia; Hollon Steven D.	Duplicate/Secondary analysis (no new data)
270	26551600	A long-term follow-up study of a randomized controlled trial of mother-infant psychoanalytic treatment: Outcomes on mothers and interactions	Infant Mental Health Journal	Salomonsson Majlis Winberg; Sorjonen Kimmo; Salomonsson Bjorn	P: Not population of interest (Not perinatal/Not postpartum)
271	27152849	Internet-provided cognitive behaviour therapy of posttraumatic stress symptoms following childbirth a randomized controlled trial	Cognitive Behaviour Therapy	Nieminen Katri; Berg Ida; Frankenstein Katri; Viita Lina; Larsson Kamilla; Persson Ulrika; Spanberger Loviisa; Wretman Anna; Silfvernagel Kristin; Andersson Gerhard; Wijma Klaas	Duplicate/Secondary analysis (no new data)
272	27627126	Effects of relaxation on depression levels in women with high-risk pregnancies: A randomised clinical trial	Revista Latino-Americana de Enfermagem	de Arajo Wanda Scherrer; Romero Walckiria Garcia; Zandonade Eliana; Costa Amorim Maria Helena	Duplicate/Secondary analysis (no new data)
273	28137316	A pilot randomized controlled trial of time-intensive cognitive behaviour therapy for postpartum obsessive-compulsive disorder: Effects on maternal symptoms, mother-infant interactions and attachment	Psychological Medicine	Challacombe F. L.; Salkovskis P. M.; Woolgar M.; Wilkinson E. L.; Read J.; Acheson R.	Duplicate/Secondary analysis (no new data)
274	N/A	The role of engagement in mindfulness-based cognitive therapy for the prevention of depressive relapse/recurrence in perinatal women	Mindfulness	Evans Amanda P. B.; Goodman Sherryl H.; Dimidjian Sona; Gallop Robert	D: Not RCT
275	31550613	The short- and long-term effectiveness of mother-infant psychotherapy on postpartum depression: A systematic review and meta-analysis	Journal of Affective Disorders	Huang Ruirui; Yang Dongqi; Lei Beimei; Yan Chunli; Tian Yumei; Huang Xin; Lei Jun	Duplicate/Secondary analysis (no new data)
276	0	Decentering and self-compassion: A randomized controlled trial of target engagement in mindful mood balance for moms		Metcalf Christina A.	D: Not RCT
277	32563204	Effectiveness of cognitive behavioural therapy for perinatal depression: A systematic review and meta-analysis	Journal of Clinical Nursing	Li Zimeng; Liu Ying; Wang Jiayao; Liu Jia; Zhang Chunmei; Liu Yanhui	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
278	33949762	Mother matters: Pilot randomized wait-list controlled trial of an online therapist-facilitated discussion board and support group for postpartum depression symptoms	Depression and Anxiety	Vigod Simone N.; Slyfield Cook Greer; Macdonald Kaeli; Hussain-Shamsy Neesha; Brown Hilary K.; de Oliveira Claire; Torshizi Kiana; Benipal Pardeep K.; Grigoriadis Sophie; Classen Catherine C.; Dennis Cindy-Lee	Duplicate/Secondary analysis (no new data)
279	N/A	Meta-analysis of the effectiveness of biological and non-biological treatments for postpartum depression	ProQuest Dissertation & Theses	Christian Sarah Jeung soon	Other...
280	N/A	Baby worries: A randomized controlled trial of mother-infant psychoanalytic treatment	ProQuest Dissertation & Theses	Salomonsson Bjorn	P: Not population of interest (Not perinatal/Not postpartum)
281	37310303	Psychological treatment of perinatal depression: A meta-analysis	Psychological Medicine	Cuijpers Pim; Franco Pamela; Ciharova Marketa; Miguel Clara; Segre Lisa; Quero Soledad; Karyotaki Eirini	D: Not RCT
282	34495285	Effect of online 1-day cognitive behavioral therapy based workshops plus usual care vs usual care alone for postpartum depression: A randomized clinical trial	JAMA Psychiatry	Van Lieshout Ryan J.; Layton Haley; Savoy Calan D.; Brown June S. L.; Ferro Mark A.; Streiner David L.; Bieling Peter J.; Feller Andrea; Hanna Steven	Duplicate/Secondary analysis (no new data)
283	34495285	Effect of online 1-day cognitive behavioral therapy based workshops plus usual care vs usual care alone for postpartum depression: A randomized clinical trial': Correction	JAMA Psychiatry	Van Lieshout Ryan J.; Layton Haley; Savoy Calan D.; Brown June S. L.; Ferro Mark A.; Streiner David L.; Bieling Peter J.; Feller Andrea; Hanna Steven	Duplicate/Secondary analysis (no new data)
284	N/A	Examining the acceptability and effectiveness of transdiagnostic, internet-delivered cognitive behaviour therapy for symptoms of postpartum anxiety and depression: A randomized controlled trial	ProQuest Dissertation & Theses	Suchan Victoria Ayla Mary	D: Not RCT
285	N/A	Personalized exploration of mindfulness-based intervention on antenatal depression: Moderated mediation analyses of a randomized controlled trial	Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues	Sun Yaoyao; Wang Juan; Mao Fangxiang; Sun Jiwei; Zhang Xuan; Cao Fenglin	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
286	35876837	Sustained remission from perinatal depression after bright light therapy: A pilot randomised, placebo controlled trial	Acta Psychiatrica Scandinavica	Garbazza Corrado; Cirignotta Fabio; D'Agostino Armando; Cicolin Alessandro; Hackethal Sandra; Wirz-Justice Anna; Cajochen Christian; Manconi Mauro	Duplicate/Secondary analysis (no new data)
287	31960525	Psychological interventions for pregnant Black women and Latinas with depression or anxiety	Clin Psychol Psychother	Ponting Carolyn Michelle	Duplicate/Secondary analysis (no new data)
288	36174135	Culturally sensitive psychotherapy for perinatal women: A mixed methods study	Journal of Consulting and Clinical Psychology	Singla Daisy R.; Hossain Sabrina; Andrejek Nicole; Cohen Matthew J.; Dennis Cindy-Lee; Kim Jo; La Porte Laura; Meltzer-Brody Samantha E.; Puerto Nino Angie; Ravitz Paula; Schoueri-Mychasiw Nour; Silver Richard; Vigod Simone N.; Zibaman Maral; Schiller Crystal E.	D: Not RCT
289	N/A	Mindfulness interventions to reduce prenatal stress and anxiety in pregnant patients		Sitjar Maricris T.	P: Not population of interest (Not perinatal/Not postpartum)
290	36504355	The effectiveness of psychological interventions for anxiety in the perinatal period: A systematic review and meta-analysis	Psychology and Psychotherapy: Theory, Research and Practice	Clinkscales Natalie; Golds Lisa; Berlouis Katherine; MacBeth Angus	Duplicate/Secondary analysis (no new data)
291	36478339	Culturally adapted psychological intervention for treating maternal depression in british mothers of african and caribbean origin: A randomized controlled feasibility trial	Clinical Psychology & Psychotherapy	Jidong Dung Ezekiel; Ike Juliet Tarela; Husain Nusrat; Murshed Maisha; Francis Christopher; Mwankon B. Shadrack; Jack B. David; Jidong John Ezekiel; Pwajok Y. Juliet; Nyam P. Pam; Kiran Tayyaba; Bassett Paul	Duplicate/Secondary analysis (no new data)
292	36700350	Associations between maternal postpartum depression and infant temperament in treatment-seeking mothers prior to and during the covid-19 pandemic	Development and Psychopathology	Chang Oswin; Huh Kathryn; Savoy Calan D.; Krzeczkowski John E.; Van Lieshout Ryan J.	D: Not RCT
293	36423436	Internet-delivered mindfulness-based interventions for mental health outcomes among perinatal women: A systematic review	Asian Journal of Psychiatry	Mao Fangxiang; Sun Yaoyao; Li Yang; Cui Naixue; Cao Fenglin	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
294	36878891	In-person 1-day cognitive behavioral therapy-based workshops for postpartum depression: A randomized controlled trial	Psychological Medicine	Van Lieshout Ryan J.; Layton Haley; Savoy Calan D.; Xie Feng; Brown June S. L.; Huh Kathryn; Bieling Peter J.; Streiner David L.; Ferro Mark A.; Haber-Evans Erika	Duplicate/Secondary analysis (no new data)
295	17943888	Psychosocial and psychological interventions for treating postpartum depression	Cochrane Database of Systematic Reviews	Dennis C. L.; Hodnett E. D.	Duplicate/Secondary analysis (no new data)
296	9099116	A controlled study of fluoxetine and cognitive-behavioral counselling in the treatment of postnatal depression	BMJ (Clinical research ed.)	Appleby L.; Warner Rwhitton Afaragher B.	D: Not RCT
297	11963345	Detection, prevention and treatment of postpartum depression: a randomized, controlled study on a sample of 859 women	Encephale	Chabrol H.; Teissedre F.; Saint-Jean M.; Teisseyre N.; Sistac C.; Michaud C.; Roge B.	Duplicate/Secondary analysis (no new data)
298	15265228	The effectiveness of a pram-walking exercise programme in reducing depressive symptomatology for postnatal women	International journal of nursing practice	Armstrong K.; Edwards H.	Not N ≥ 10 /group
299	15973255	A randomized controlled trial of the effects of applied relaxation training on reducing anxiety and perceived stress in pregnant women	Journal of midwifery & women's health	Bastani F.; Hidarnia A.; Kazemnejad A.; Vafaei M.; Kashanian M.	P: Not population of interest (Not perinatal/Not postpartum)
300	20177281	Acupuncture for depression during pregnancy: a randomized controlled trial	Obstetrics and gynecology	Manber R.; Schnyer R. N.; Lyell D.; Chambers A. S.; Caughey A. B.; Druzin M.; Carlyle E.; Celio C.; Gress J. L.; Huang M. I.; et al.	Duplicate/Secondary analysis (no new data)
301	N/A	Acupuncture for depression during pregnancy	American journal of obstetrics and gynecology	Manber R.; Schnyer R.; Chambers A.; Lyell D.; Caughey A.; Carlyle E.	Not full report (eg, conference abstract)
302	N/A	A randomised controlled trial of cognitive therapy for antenatal depression	Controlled-trials.com	Evans J.	Not full report (eg, conference abstract)
303	20860888	A pragmatic randomised controlled trial to compare antidepressants with a community-based psychosocial intervention for the treatment of women with postnatal depression: the RESPOND trial	Health technology assessment (Winchester, England)	Sharp D. J.; Chew-Graham C.; Tylee A.; Lewis G.; Howard L.; Anderson I.; Abel K.; Turner K. M.; Hollinghurst S. P.; Tallon D.; et al.	Duplicate/Secondary analysis (no new data)
304	N/A	Acupuncture for depression during pregnancy: a controlled randomized trial	Revista internacional de acupuntura	Ortiz M.	Not full report (eg, conference abstract)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
305	21535997	A randomized, double-blind, placebo-controlled study of light therapy for antepartum depression	Journal of clinical psychiatry	Wirz-Justice A.; Bader A.; Frisch U.; Stieglitz R. D.; Alder J.; Bitzer J.; Hosli I.; Jazbec S.; Benedetti F.; Terman M.; et al.	Duplicate/Secondary analysis (no new data)
306	22840621	Randomized non-invasive sham-controlled pilot trial of electroacupuncture for postpartum depression	Journal of affective disorders	Chung K. F.; Yeung W. F.; Zhang Z. J.; Yung K. P.; Man S. C.; Lee C. P.; Lam S. K.; Leung T. W.; Leung K. Y.; Ziea E. T.; et al.	Duplicate/Secondary analysis (no new data)
307	20936338	An open trial of in-home CBT for depressed mothers in home visitation	Maternal and child health journal	Ammerman R. T.; Putnam F. W.; Stevens J.; Bosse N. R.; Short J. A.; Bodley A. L.	Duplicate/Secondary analysis (no new data)
308	N/A	Effect of exercise program on symptoms of postpartum depression	Iranian journal of obstetrics, gynecology and infertility	Saeedi S.	S: Not high-income country
309	N/A	Efficacy of yoga for depressed postpartum women: a randomized controlled trial	Dissertation abstracts international: section B: the sciences and engineering dissertation abstracts international	Buttner Melissa Mercedes	Other...
310	N/A	Multidisciplinary model of nurse midwife administered psychotherapy for postpartum depression	Archives of women's mental health	Posmontier B.; Stuart S.; Neugebauer R.; Shaughnessy R.	Not full report (eg, conference abstract)
311	N/A	Effectiveness of cognitive-behavioral stress management intervention on anxiety and depression during pregnancy	Journal of kerman university of medical sciences	Karamoozian M.; Askarizadeh G.	S: Not high-income country
312	N/A	The feasibility of yoga in the treatment of antenatal depression and anxiety: a pilot study	Dissertation abstracts international: section B: the sciences and engineering dissertation abstracts international	Davis Kyle J.	Duplicate/Secondary analysis (no new data)
313	N/A	Anticipate: a pilot randomised trial of CBT for antenatal depression and validation of depression screening by midwives	Archives of women's mental health	Evans J.; Noble A.; Baxter H.; Bennert K.; O'Mahen H.; Turner K.; Ramchandani P.; Wiles N.; Sharp D.	Not full report (eg, conference abstract)
314	N/A	Synthesis: bright morning light therapy for antenatal depression	Archives of women's mental health	Wisner K. L.; Sit D. K. Y.	Not full report (eg, conference abstract)
315	N/A	Momcare: culturally relevant treatment services for perinatal depression	Archives of women's mental health	Grote N.; Katon W.; Lohr M. J.	Not full report (eg, conference abstract)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
316	N/A	Preliminary results of cognitive behavioral stress management (CBSM) on cortisol levels among low-income pregnant women: the smart MOMS project	Psychosomatic medicine	Urizar G.; Yim I. S.; Schetter C. D.	Not full report (eg, conference abstract)
317	N/A	A pilot randomized controlled trial of cognitive behavioural therapy for women with antenatal depression: infant temperament and sleep	Archives of women's mental health	Netsi E.; Jonathan E.; Heather O.; Alison B.; Paul R.	Not full report (eg, conference abstract)
318	N/A	Cognitive behavioral therapy for treatment of antenatal anxiety and depressive symptoms: a randomized controlled trial	Archives of women's mental health	Beijers C.; Verbeek T.; Van Pampus M. G.; Meijer J. L.; Burger H.; Bockting C. L. H.	Not full report (eg, conference abstract)
319	N/A	Multidisciplinary model of nurse midwife administered psychotherapy for postpartum depression	Archives of women's mental health	Posmontier B.; Neugebauer R.; Stuart S.; Shaughnessy R.; Chittams J.	Not full report (eg, conference abstract)
320	N/A	A multi-site randomized controlled trial to evaluate the effect of telephone-based interpersonal psychotherapy by trained nurses for the treatment of postpartum depression	Archives of women's mental health	Dennis C. L.; Ravitz P.; Grigoriadis S.; Jovellanos M.; Hodnett E.; Ross L.; Zupancic J.	Not full report (eg, conference abstract)
321	N/A	Interactions and attachment in infants of mothers with OCD	Archives of women's mental health	Challacombe F.; Salkovskis P.; Woolgar M.	Not full report (eg, conference abstract)
322	N/A	CBT for low income perinatal women	Archives of women's mental health	Mahen H. O.; Himle J.; Fedoc G.; Flynn H.	Not full report (eg, conference abstract)
323	N/A	Pilot results on child outcomes of antenatal depression treatment	Archives of women's mental health	Milgrom J.; Holt C.; Schembri C.; Gemmill A.	Not full report (eg, conference abstract)
324	N/A	Exercise as an adjunct therapy for postnatal depression: a pilot study	Archives of women's mental health	Boath E.; Henshaw C.; Forsyth J.	Not full report (eg, conference abstract)
325	N/A	Development of a CBT program for depression during pregnancy-beating the blues before birth	Archives of women's mental health	Milgrom J.; Holt C.; Schembri C.; Gemmill A.	Not full report (eg, conference abstract)
326	26595300	THE EFFECTS OF EXPRESSIVE WRITING ON POSTPARTUM DEPRESSION AND POSTTRAUMATIC STRESS SYMPTOMS	Psychological reports	Blasio P. D.; Camisasca E.; Caravita S. C.; Ionio C.; Milani L.; Valtolina G. G.	Duplicate/Secondary analysis (no new data)
327	26385456	A pilot randomized controlled trial comparing prenatal yoga to perinatal health education for antenatal depression	Arch women's mental health	Uebelacker Lisa A.; Battle Cynthia L.; Sutton Kaeli A.; Magee Susanna R.; Miller Ivan W.	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
328	25804297	A pragmatic randomized controlled trial to evaluate the effectiveness of a facilitated exercise intervention as a treatment for postnatal depression: the PAM-PeRS trial	Psychological medicine	Daley A. J.; Blamey R. V.; Jolly K.; Roalfe A. K.; Turner K. M.; Coleman S.; McGuinness M.; Jones I.; Sharp D. J.; MacArthur C.	Duplicate/Secondary analysis (no new data)
329	25062520	Early intervention in pregnant women with elevated anxiety and depressive symptoms: efficacy of a cognitive-behavioral group program	Journal of perinatal & neonatal nursing	Bittner A.; Peukert J.; Zimmermann C.; Junge-Hoffmeister J.; Parker L. S.; Stobel-Richter Y.; Weidner K.	Duplicate/Secondary analysis (no new data)
330	28045285	A pragmatic randomized clinical trial of behavioral activation for depressed pregnant women	Journal of consulting and clinical psychology	Dimidjian S.; Goodman S. H.; Sherwood N. E.; Simon G. E.; Ludman E.; Gallop R.; Welch S. S.; Boggs J. M.; Metcalf C. A.; Hubley S.; et al.	Duplicate/Secondary analysis (no new data)
331	28258027	Impact of an educational DVD on anxiety and glycaemic control in women diagnosed with gestational diabetes mellitus (GDM): a randomised controlled trial	Diabetes research and clinical practice	Draffin C. R.; Alderdice F. A.; McCance D. R.; Maresh M.; Harper R.; Patterson C. C.; Bernatavicius G.; Brennan S. F.; Gough A.; McSorley O.; et al.	P: Not disorder of interest
332	28287802	Depressive Symptoms and Gestational Length Among Pregnant Adolescents: cluster Randomized Control Trial of Centering Pregnancy Plus Group Prenatal Care	Journal of consulting and clinical psychology. (no pagination), 2017	Felder J. N.; Epel E.; Lewis J. B.; Cunningham S. D.; Tobin J. N.; Rising S. S.; Thomas M.; Ickovics J. R.	Duplicate/Secondary analysis (no new data)
333	27821114	Bright light therapy in pregnant women with major depressive disorder: study protocol for a randomized, double-blind, controlled clinical trial	BMC psychiatry	Bais B.; Kamperman A. M.; van der Zwaag M. D.; Dieleman G. C.; Harmsen van der Vliet-Torij H. W.; Bijma H. H.; Lieveerse R.; Hoogendijk W. J.; Lambregtse-van den Berg M. P.	Other...
334	28721461	Influence of adjuvant detached mindfulness and stress management training compared to pharmacologic treatment in primiparae with postpartum depression	Archives of women's mental health	Ahmadpanah M.; Nazariabadie M.; Aghaei E.; Ghaleiha A.; Bakhtiari A.; Haghighi M.; Bahmani D. S.; Akhondi A.; Bajoghli H.; Jahangard L.; et al.	Duplicate/Secondary analysis (no new data)
335	28593360	Strongest Families™ Managing Our Mood (MOM): a randomized controlled trial of a distance intervention for women with postpartum depression	Archives of women's mental health	Wozney L.; Olthuis J.; Lingley-Pottie P.; McGrath P. J.; Chaplin W.; Elgar F.; Cheney B.; Huguet A.; Turner K.; Kennedy J.	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
336	28614554	Efficacy of a Maternal Depression Prevention Strategy in Head Start: a Randomized Clinical Trial	JAMA psychiatry	Silverstein M.; Diaz-Linhart Y.; Cabral H.; Beardslee W.; Hegel M.; Haile W.; Sander J.; Patts G.; Feinberg E.	P: Not disorder of interest
337	N/A	Early vs. Late wake therapy improves mood in antepartum vs. Postpartum depression by differentially altering melatonin and sleep timing	Journal of affective disorders	Parry, B.L., Meliska, C.J., Lopez, A.M., Sorenson, D.L., Martinez, L.F., Orff, H.J., Hauger, R.L. and Kripke, D.F	Duplicate/Second ary analysis (no new data)
338	N/A	The effectiveness of relaxation techniques on depression, anxiety and stress in pregnant women: based on self-efficacy theory	Scientific journal of kurdistan university of medical sciences	Alipoor M.; Ghahremani L.; Amooee S.; Keshavarzi S.	S: Not high-income country
339	28482901	Prenatal listening to songs composed for pregnancy and symptoms of anxiety and depression: a pilot study	BMC complementary and alternative medicine	Nwebube C.; Glover V.; Stewart L.	P: Not disorder of interest
340	27152849	Internet-provided cognitive behaviour therapy of posttraumatic stress symptoms following childbirth-a randomized controlled trial	Cognitive behaviour therapy	Nieminen K.; Berg I.; Frankenstein K.; Viita L.; Larsson K.; Persson U.; Spanberger L.; Wretman A.; Silfvernagel K.; Andersson G.; et al.	Duplicate/Second ary analysis (no new data)
341	28628768	Internet delivered cognitive behavior therapy for antenatal depression: a randomised controlled trial	Journal of affective disorders	Forsell E.; Bendix M.; Hollandare F.; Szymanska von Schultz B.; Nasiell J.; Blomdahl-Wetterholm M.; Eriksson C.; Kvarneld S.; Lindau van der Linden J.; Soderberg E.; et al.	Duplicate/Second ary analysis (no new data)
342	29413138	Mitigating the effect of persistent postnatal depression on child outcomes through an intervention to treat depression and improve parenting: a randomised controlled trial	The lancet. Psychiatry	Stein A.; Netsi E.; Lawrence P. J.; Granger C.; Kempton C.; Craske M. G.; Nickless A.; Mollison J.; Stewart D. A.; Rapa E.; et al.	Duplicate/Second ary analysis (no new data)
343	27480668	Using Prenatal Advocates to Implement a Psychosocial Education Intervention for Posttraumatic Stress Disorder during Pregnancy: feasibility, Care Engagement, and Predelivery Behavioral Outcomes	Women's health issues	Upshur C. C.; Wenz-Gross M.; Weinreb L.; Moffitt J. J. A.	Duplicate/Second ary analysis (no new data)
344	N/A	Cognitive Behavioural Group Therapy for Perinatal Anxiety	https://clinicaltrials.gov/show/NCT02850523	Nct	O: No results reported (registry)
345	N/A	Randomised Control Trial of a Complex Intervention for Postnatal Depression	https://clinicaltrials.gov/show/NCT01309516	Nct	O: No results reported (registry)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
346	N/A	Mother-Infant Intervention for Postpartum Depression and Associated Mother-Infant Relationship Dysfunction	https://clinicaltrials.gov/show/NCT02057627	Nct	O: No results reported (registry)
347	N/A	Telephone-based cognitive-behavioral therapy on postnatal depression and quality of life	BJOG	Ngai F. W.	Not full report (eg, conference abstract)
348	30266030	A randomized controlled trial of 'MUMentum Pregnancy': internet-delivered cognitive behavioral therapy program for antenatal anxiety and depression	Journal of affective disorders	Loughnan S. A.; Sie A.; Hobbs M. J.; Joubert A. E.; Smith J.; Haskelberg H.; Mahoney A. E. J.; Kladnitski N.; Holt C. J.; Milgrom J.; et al.	Duplicate/Secondary analysis (no new data)
349	N/A	Culturally relevant psychotherapy for perinatal depression	Archives of women's mental health	Grote N. K.; Swartz H. A.; Geibel S.; Frank E.	Not full report (eg, conference abstract)
350	N/A	Psychological treatment of antenatal depression and anxiety: effects on obstetric outcomes	Archives of women's mental health	Verbeek T.; Ci L. H.; Meijer J. L.; Beijers C.; Van Pampus M. G.; Burger H.	Not full report (eg, conference abstract)
351	N/A	TCM acupuncture provides clinically relevant improvement in depression during pregnancy	Focus on alternative and complementary therapies	Lee H.	Not full report (eg, conference abstract)
352	N/A	Psychological treatment of antenatal depression and anxiety: effects on obstetric outcomes	Archives of women's mental health	Verbeek T.; Bockting C. L. H.; Meijer J. L.; Beijers C.; Van Pampus M. G.; Burge H.	Duplicate/Secondary analysis (no new data)
353	N/A	80: effects of cognitive behavioural therapy for antenatal anxiety and depression on mother and offspring	American journal of obstetrics and gynecology	Burger H.; Verbeek T.; Meijer J.; Beijers C.; Mol B.; Ormel J.; van Pampus M.; Bockting C.	Not full report (eg, conference abstract)
354	30877878	A randomised controlled trial of 'MUMentum postnatal': internet-delivered cognitive behavioural therapy for anxiety and depression in postpartum women	Behaviour research and therapy	Loughnan S. A.; Butler C.; Sie A. A.; Grierson A. B.; Chen A. Z.; Hobbs M. J.; Joubert A. E.; Haskelberg H.; Mahoney A.; Holt C.; et al.	Duplicate/Secondary analysis (no new data)
355	N/A	Influence of adjuvant detached mindfulness and stress management training compared to pharmacologic treatment in primiparae with postpartum depression	Pharmacopsychiatry	Sadeghi Bahmani D.; Ahmadpanah M.; Haghighi M.; Akhondi A.; Ghaleiha A.; Jahangard L.; Holsboer-Trachsler S.	Duplicate/Secondary analysis (no new data)
356	N/A	Influence of adjuvant metacognitive detached mindfulness and stress management training compared to pharmacologic treatment in primiparae with postpartum depression	Swiss medical weekly	Brand S.; Ahmadpanah M.; Haghighi M.; Sadeghi Bahmani D.; Holsboer-Trachsler E.	Duplicate/Secondary analysis (no new data)
357	N/A	Light Therapy for Depression During Pregnancy	https://clinicaltrials.gov/show/NCT01043289	Nct	O: No results reported (registry)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
358	31805778	The EMDR Recent Birth Trauma Protocol: a pilot randomised clinical trial after traumatic childbirth	Psychology & health	Chiorino V.; Cattaneo M. C.; Macchi E. A.; Salerno R.; Roveraro S.; Bertolucci G. G.; Mosca F.; Fumagalli M.; Cortinovis I.; Carletto S.; et al.	Duplicate/Secondary analysis (no new data)
359	N/A	Mood and sleep improvement with critically-timed wake and light interventions in premenstrual, peripartum vs. perimenopausal depression depend on specific underlying melatonin and sleep circadian phase disturbances	Sleep medicine	Parry B.; Meliska C.; Sorenson D.; Martinez F.; Lopez A.; Dawes S.; Hauger R.; Kripke D.	Not full report (eg, conference abstract)
360	N/A	The evaluation of acupuncture as an adjunct intervention for antenatal depression: a pragmatic randomised controlled trial	Journal of alternative and complementary medicine (New York, N.Y.)	Ormsby S.; Smith C.; Dahlen H.; Hay P.	Other...
361	N/A	Critically-timed wake and light therapy: mood effects on premenstrual, peripartum and menopausal depression depend on melatonin-sleep timing	Neuropsychobiology	Parry B.; Meliska C.; Sorenson D.; Martinez L. F.; Lopez A.; Dawes S.; Hauger R.; Kripke D.	Not full report (eg, conference abstract)
362	N/A	Mindfulness-based Intervention for Postnatal Depression	https://clinicaltrials.gov/show/NCT04332146	Nct	O: No results reported (registry)
363	N/A	Regaining MUMentum: findings from two randomized controlled trials evaluating brief internet cognitive behavioral therapy for perinatal distress, anxiety, and depression	Archives of women's mental health	Loughnan S.	Not full report (eg, conference abstract)
364	N/A	Regaining 'MUMentum': randomized controlled trial of online CBT for perinatal distress, anxiety, and depression	Archives of women's mental health	Loughnan Sa- M.; Newby J.; Andrews G.; Butler C.	Not full report (eg, conference abstract)
365	N/A	Maternal antenatal mood and child development: an exploratory study of treatment effects on child outcomes up to 5 years	Archives of women's mental health	Milgrom J.; Holt C. J.; Bleker L.; Holt C.; Ross J.; Ericksen J.; Glover V.; O'Donnell K. J.; De Rooij S.; Gemmill A. W.	Duplicate/Secondary analysis (no new data)
366	31823163	The Effect of Expressive Writing on Postpartum Depression and Stress of Mothers with a Preterm Infant in NICU	Journal of clinical psychology in medical settings	Rabiepoor S.; Vatankhah-Alamdary N.; Khalkhali H. R.	S: Not high-income country
367	32409986	A pilot study of a group-based perinatal depression intervention on reducing depressive symptoms and improving maternal-fetal attachment and maternal sensitivity	Archives of women's mental health	Alhusen J. L.; Hayat M. J.; Borg L.	Duplicate/Secondary analysis (no new data)
368	N/A	Treatment of Intrapartum Depression Using Non-invasive Photobiomodulation	https://clinicaltrials.gov/show/NCT04404231	Nct	O: No results reported (registry)
369	N/A	Light Therapy to Improve Symptoms in Pregnant Women With Major Depressive Disorder	https://clinicaltrials.gov/show/NCT04447430	Nct	O: No results reported (registry)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
370	N/A	The effect of writing therapy on anxiety in pregnant women: a randomized controlled trial	Iranian journal of psychiatry and behavioral sciences	Montazeri M.; Esmailpour K.; Mohammad-Alizadeh-Charandabi S.; Golizadeh S.; Mirghafourvand M.	S: Not high-income country
371	N/A	Treatment for antenatal anxiety and depression with Beating the Blues before Birth BBB positively impacts infant postnatal development at 9 months, a pilot RCT	Archives of women's mental health	Ericksen J.; Milgrom J.; Holt C.; Ross J.; Gemmill A.	Not full report (eg, conference abstract)
372	N/A	Internet cognitive behavioural therapy for women with postnatal depression: a randomized controlled trial of MumMoodBooster	Archives of women's mental health	Milgrom J.; Danaher B. G.; Gemmill A. W.; Holt C.; Holt C. J.; Seeley J. R.; Tyler M. S.; Ross J.; Ericksen J.	Duplicate/Secondary analysis (no new data)
373	N/A	Early intervention to protect the mother-infant relationship following postnatal depression: a randomised controlled trial	Archives of women's mental health	Milgrom J.; Holt C.; Gemmill A. W.; Ericksen J.	Not full report (eg, conference abstract)
374	32116849	Cognitive Behavioral Therapy for Antenatal Depression in a Pilot Randomized Controlled Trial and Effects on Neurobiological, Behavioral and Cognitive Outcomes in Offspring 3, 7 Years Postpartum: a Perspective Article on Study Findings, Limitations and Future Aims	Frontiers in psychiatry	Bleker L. S.; Milgrom J.; Sexton-Oates A.; Parker D.; Roseboom T. J.; Gemmill A. W.; Holt C. J.; Saffery R.; Connelly A.; Burger H.; et al.	Duplicate/Secondary analysis (no new data)
375	N/A	Peer support for antenatal depression (AND): a feasibility study for a randomised controlled trial	Journal of reproductive and infant psychology	Boath E.; Cust F.; Carter R.	Not full report (eg, conference abstract)
376	33949762	Mother Matters: pilot randomized wait-list controlled trial of an online therapist-facilitated discussion board and support group for postpartum depression symptoms	Depression and anxiety	Vigod S. N.; Slyfield Cook G.; Macdonald K.; Hussain-Shamsy N.; Brown H. K.; de Oliveira C.; Torshizi K.; Benipal P. K.; Grigoriadis S.; Classen C. C.; et al.	Duplicate/Secondary analysis (no new data)
377	N/A	Online Peer-Delivered 1-Day CBT Workshops for PPD	https://clinicaltrials.gov/show/NCT04934488	Nct	O: No results reported (registry)
378	N/A	LTP and CBT for Treating Postnatal Depression in British Mothers of African and Caribbean Origin	https://clinicaltrials.gov/show/NCT05148260	Nct	O: No results reported (registry)
379	34914418	Cognitive Behavioral Stress Management Effects on Prenatal Anxiety Among Low-Income Women	Journal of consulting and clinical psychology	Ponting C.; Chavira D. A.; Schetter C. D.; Urizar G. G.	Duplicate/Secondary analysis (no new data)
380	35842616	Web-based treatment for depression in pregnancy: a feasibility study of Mum2BMoodBooster	BMC psychiatry	Gemmill A. W.; Oliva J. L.; Ericksen J.; Holt C.; Holt C. J.; Milgrom J.	D: Not RCT

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
381	N/A	Yoga exercises can reduce prenatal maternal stress	European psychiatry	Kiselev S.	Not full report (eg, conference abstract)
382	36478339	Culturally adapted psychological intervention for treating maternal depression in British mothers of African and Caribbean origin: a randomised controlled feasibility trial	Clinical psychology & psychotherapy	Ezekiel J. D.; Tarela I. J.; Nusrat H.; Maisha M.; Christopher F.; Shadrack M. B.; David J. B.; Ezekiel J. J.; Juliet P. Y.; Pam N. P.; et al.	Duplicate/Secondary analysis (no new data)
383	36586616	Critically-timed sleep and light interventions differentially improve mood in pregnancy vs. postpartum depression by shifting melatonin rhythms	Journal of affective disorders	Parry B. L.; Meliska C. J.; Sorenson D. L.; Martinez L. F.; Lopez A. M.; Dawes S. E.; Elliott J. A.; Hauger R. L.	Duplicate/Secondary analysis (no new data)
384	N/A	Effects of support group intervention in postnatally distressed women: a controlled study in Taiwan		Chen C.; Tseng Y.; Chou F.; Wang S.	S: Not high-income country
385	26571104	Clinical management of perinatal anxiety disorders: A systematic review	J Affect Disord	Marchesi C.; Ossola P.; Amerio A.; Daniel B. D.; Tonna M.; De Panfilis C.	Other...
386	27182732	The Effectiveness of Mindfulness-Based Interventions in the Perinatal Period: A Systematic Review and Meta-Analysis	PLoS One	Lever Taylor B.; Cavanagh K.; Strauss C.	P: Not population of interest (Not perinatal/Not postpartum)
387	27539908	The effects of mindfulness interventions on prenatal well-being: A systematic review	Psychol Health	Matvienko-Sikar K.; Lee L.; Murphy G.; Murphy L.	P: Not disorder of interest
388	34555958	Effects of maternal stress and/or anxiety interventions in the first 1000 days: Systematic review of reviews	Journal of Reproductive & Infant Psychology	Matvienko-Sikar Karen; Redsell Sarah; Flannery Caragh	Other...
389	15367053	Treatment of Postpartum Depression, Part 1: A Critical Review of Biological Interventions	The Journal of Clinical Psychiatry	Dennis Cindy-Lee E.; Stewart Donna E.	Duplicate/Secondary analysis (no new data)
390	15367054	Treatment of Postpartum Depression, Part 2: A Critical Review of Nonbiological Interventions	The Journal of Clinical Psychiatry	Dennis Cindy-Lee E.	Duplicate/Secondary analysis (no new data)
391	21735413	Mind-body interventions during pregnancy for preventing or treating women's anxiety	Cochrane Database of Systematic Reviews	Marc I.; Toureche N.; Ernst E.; Hodnett E. D.; Blanchet C.; Dodin S.; Njoya M. M.	Duplicate/Secondary analysis (no new data)
392	33580709	Antidepressant treatment for postnatal depression	Cochrane database of systematic reviews (Online)	Brown J. V. E.; Wilson C. A.; Ayre K.; South E.; Molyneaux E.; Trevillion K.; Howard L. M.; Khalifeh H.	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
393	28994626	PRogram In Support of Moms (PRISM): a pilot group randomized controlled trial of two approaches to improving depression among perinatal women	Journal of psychosomatic obstetrics and gynaecology	Byatt N.; Moore Simas T. A.; Biebel K.; Sankaran P.; Pbert L.; Weinreb L.; Ziedonis D.; Allison J.	I: No intervention of interest
394	12655910	The effect of peer support on postpartum depression: A pilot randomized controlled trial	Canadian Journal of Psychiatry	Dennis C. L.	P: Not disorder of interest
395	21385294	Effect of home-based peer support on maternal-infant interactions among women with postpartum depression: A randomized, controlled trial	International Journal of Mental Health Nursing	Letourneau Nicole; Stewart Miriam; Dennis Cindy-Lee; Hegadoren Kathleen; Duffett-Leger Linda; Watson Barry	Duplicate/Secondary analysis (no new data)
396	36360528	Effectiveness of a Mobile Application for Postpartum Depression Self-Management: Evidence from a Randomised Controlled Trial in South Korea	Healthcare (2227-9032)	Seo Ji-Min; Kim Su-Jeong; Na Hyunjoo; Kim Jin-Hee; Lee Hyejin	P: Not disorder of interest
397	N/A	Preventing Depressive Relapse in Pregnant Women With Recurrent Depression	https://clinicaltrials.gov/show/NCT03623620	Nct	
398	31121887	Brain Magnetic Resonance Imaging Findings in Children after Antenatal Maternal Depression Treatment, a Longitudinal Study Built on a Pilot Randomized Controlled Trial	Int J Environ Res Public Health	Bleker L. S.; Milgrom J.; Parker D.; Gemmill A. W.; Holt C. J.; Connelly A.; Burger H.; Roseboom T. J.; de Rooij S. R.	Other...
399	15715034	Massage therapy effects on depressed pregnant women	J Psychosom Obstet Gynaecol	Field T.; Diego M. A.; Hernandez-Reif M.; Schanberg S.; Kuhn C.	Other...
400	26261095	Performance of a Culturally Tailored Cognitive-Behavioral Intervention Integrated in a Public Health Setting to Reduce Risk of Antepartum Depression: A Randomized Controlled Trial	J Midwifery Womens Health	Jesse D. E.; Gaynes B. N.; Feldhousen E. B.; Newton E. R.; Bunch S.; Hollon S. D.	P: Not disorder of interest
401	24061387	Brief Internet-based intervention reduces posttraumatic stress and prolonged grief in parents after the loss of a child during pregnancy: a randomized controlled trial	Psychother Psychosom	Kersting A.; Dolemeier R.; Steinig J.; Walter F.; Kroker K.; Baust K.; Wagner B.	P: Not population of interest (Not perinatal/Not postpartum)
402	10986574	The impact of partner support in the treatment of postpartum depression	Can J Psychiatry	Misri S.; Kostaras X.; Fox D.; Kostaras D.	Other...
403	11246096	Infant massage improves mother-infant interaction for mothers with postnatal depression	J Affect Disord	Onozawa K.; Glover V.; Adams D.; Modi N.; Kumar R. C.	I: No intervention of interest
404	25522664	Perinatal Dyadic Psychotherapy for postpartum depression: a randomized controlled pilot trial	Arch Womens Ment Health	Goodman J. H.; Prager J.; Goldstein R.; Freeman M.	I: No intervention of interest
405	33742282	Improving the mother-infant relationship following postnatal depression: a randomised controlled trial of a brief intervention (HUGS)	Arch Womens Ment Health	Holt C.; Gentileau C.; Gemmill A. W.; Milgrom J.	I: No intervention of interest

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
406	24778436	A pilot randomised controlled trial to evaluate the feasibility and acceptability of the Baby Triple P Positive Parenting Programme in mothers with postnatal depression	Clin Child Psychol Psychiatry	Tsivos Z. L.; Calam R.; Sanders M. R.; Wittkowski A.	I: No intervention of interest
407	N/A	Effects of mindfulness-based cognitive therapy in pregnancy on psychological distress and gestational age: Outcomes of a randomized controlled trial	Mindfulness	MacKinnon Anna L.; Madsen Joshua W.; Giesbrecht Gerald F.; Campbell Tavis; Carlson Linda E.; Dimidjian Sona; Letourneau Nicole; Tough Suzanne; Tomfohr-Madsen Lianne	P: Not disorder of interest
408	19083666	Massage therapy reduces pain in pregnant women, alleviates prenatal depression in both parents and improves their relationships	J Bodyw Mov Ther	Field T.; Figueiredo B.; Hernandez-Reif M.; Diego M.; Deeds O.; Ascencio A.	I: No intervention of interest
409	25016216	Culturally relevant treatment services for perinatal depression in socio-economically disadvantaged women: the design of the MOMCare study	Contemp Clin Trials	Grote N. K.; Katon W. J.; Lohr M. J.; Carson K.; Curran M.; Galvin E.; Russo J. E.; Gregory M.	I: No intervention of interest
410	26345179	COLLABORATIVE CARE FOR PERINATAL DEPRESSION IN SOCIOECONOMICALLY DISADVANTAGED WOMEN: A RANDOMIZED TRIAL	Depress Anxiety	Grote N. K.; Katon W. J.; Russo J. E.; Lohr M. J.; Curran M.; Galvin E.; Carson K.	I: No intervention of interest
411	28076671	A Randomized Trial of Collaborative Care for Perinatal Depression in Socioeconomically Disadvantaged Women: The Impact of Comorbid Posttraumatic Stress Disorder	J Clin Psychiatry	Grote N. K.; Katon W. J.; Russo J. E.; Lohr M. J.; Curran M.; Galvin E.; Carson K.	I: No intervention of interest
412	29678804	Feasibility and Acceptability of a Web-Based Treatment with Telephone Support for Postpartum Women With Anxiety: Randomized Controlled Trial	JMIR Ment Health	Ashford M. T.; Olander E. K.; Rowe H.; Fisher J. R.; Ayers S.	P: Not disorder of interest
413	19616143	Effects of home-based exercise on fatigue in postpartum depressed women: who is more likely to benefit and why?	Journal of psychosomatic research	Dritsa M.; Dupuis G.; Lowensteyn I.; Da Costa D.	O: No outcome of interest
414	17459185	Effective treatment for postpartum depression is not sufficient to improve the developing mother-child relationship	Dev Psychopathol	Forman D. R.; O'Hara M. W.; Stuart S.; Gorman L. L.; Larsen K. E.; Coy K. C.	I: No intervention of interest
415	37074698	Effect of Brief Interpersonal Therapy on Depression During Pregnancy: A Randomized Clinical Trial	JAMA Psychiatry	Hankin B. L.; Demers C. H.; Hennessey E. P.; Perzow S. E. D.; Curran M. C.; Gallop R. J.; Hoffman M. C.; Davis E. P.	I: No intervention of interest

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
416	31726954	Randomized controlled trial of the Circle of Security-Intensive intervention for mothers with postpartum depression: maternal unresolved attachment moderates changes in sensitivity	Attach Hum Dev	Ramsauer B.; Muhlhan C.; Lotzin A.; Achtergarde S.; Mueller J.; Krink S.; Tharner A.; Becker-Stoll F.; Nolte T.; Romer G.	I: No intervention of interest
417	36371154	Effect of internet-based cognitive behaviour therapy among women with negative birth experiences on mental health and quality of life - a randomized controlled trial	BMC Pregnancy Childbirth	Sjomark J.; Svanberg A. S.; Larsson M.; Viirman F.; Poromaa I. S.; Skalkidou A.; Jonsson M.; Parling T.	P: Not disorder of interest
418	N/A	Effects of Exercise on Women With Postpartum Depression: A Systematic Review of the Literature	N/A	Adams V.; Volo J.; Burnside A.; Cross J.; Kalafut M.; Figuers C.	Unable to retrieve full text
419	N/A	A randomized, double-blind controlled clinical trial of light therapy for pregnant women with major depressive disorder	NEUROPSYCHOBIOLOGY	Bais B.	Unable to retrieve full text
420	11963345	[Detection, prevention and treatment of postpartum depression: a controlled study of 859 patients]	Encephale	Chabrol H.; Teissedre F.; Saint-Jean M.; Teisseyre N.; Sistac C.; Michaud C.; Roge B.	P: Not disorder of interest
421	29383894	[Effects of Transcutaneous Electrical Acupoint Stimulation for Depression in Late Pregnancy and Impacts on Inflammatory Cytokines]	Zhen Ci Yan Jiu	Chen W. Y.; Li L.; Wang H. Y.; Jiang N.	Unable to retrieve full text
422	32503517	Online yoga to reduce post traumatic stress in women who have experienced stillbirth: a randomized control feasibility trial	BMC Complement Med Ther	Huberty J.; Sullivan M.; Green J.; Kurka J.; Leiferman J.; Gold K.; Cacciatore J.	P: Not population of interest (Not perinatal/Not postpartum)
423	N/A	Screening, prevention and postpartum treatment: a randomized comparative study on 450 women	Screening, prevention and postpartum treatment: a randomized comparative study on 450 women	Teissedre F.; Chabrol H.	P: Not disorder of interest
424	N/A	Effect of acupuncture plus psychological intervention on 5-HT, OFQ and E2 in Patients with postpartum depression	Shanghai Journal of Acupuncture and Moxibustion	Xi Y. X.; Wang Y.	Unable to retrieve full text
425	N/A	Therapeutic efficacy of acupuncture at the thirteen ghost points for postpartum depression and its effect on the quality of life	Shanghai Journal of Acupuncture and Moxibustion	Yu S. J.; Li X. Q.; Feng X. M.; Cao W. F.	Unable to retrieve full text

Appendix C. Evidence Map Tables, Study Design, and Baseline Tables

Table C-1. KQ 1: Evidence map

Study	Mental Health Condition (Inclusion Criteria)	Perinatal Period	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
Chabrol, 2002, 12214785	Depressive disorder (EPDS \geq 11, MINI)	Postpartum/ Postnatal	CBT + Psychoeducation (N=18)	TAU (N=30)	Recovery rates based on HDRS scores of <7 and BDI scores of <4 were also significantly greater in the treated group than in the control group.
Buttner, 2015, 25886805	Depressive Disorder (HADS \geq 12)	Postpartum/ Postnatal	Yoga (N = 28)	Waitlist control (N = 29)	Depressive symptoms, anxiety symptoms, and health related quality of life were significantly improved in the yoga group, compared with the control group at the end of treatment.
Challacombe, 2024, 37848088	Anxiety disorder (DSM-5)	Antenatal/ Prenatal	Time-intensive delivery of CBT (INT-CBT) (N= 29)	Standard weekly one-hour CBT sessions (WCBT) (N= 30)	Women receiving INT-CBT showed a reduction in anxiety (GAD-7) after two weeks of treatment compared to WCBT with narrower difference at 3-month postpartum.
Cluxton-Keller, 2023, 37921846	Depressive disorder (BDI-II \geq 20)	Antenatal/ Prenatal	Experimental family therapeutic intervention, Resilience Enhancement Skills Training (REST) (N=42)	Standard of care (Videoconferencing technology (VCT)-based problem-solving individual therapy) (N=41)	The results showed that REST is safe for perinatal women with moderate to severe depressive symptoms, and none discontinued due to worsened depressive symptoms. REST is well tolerated by families, and no families discontinued due to sustained family conflict.
Evans, 2021, 34649534	Depressive disorders (CIS-R, EPDS \geq 10)	Antenatal/ Prenatal	IPT + Interpersonal counseling (N=26)	CBT (N=26)	There was improvement in mood in both groups rated by change in EPDS score.
Fancourt, 2018, 29436333	Depression (EPDS \geq 10)	Postpartum/ Postnatal	Singing (N=30)	Playgroup (N=23), TAU (N=22)	There was a nonsignificant faster improvement in symptoms in the singing group ($p = 0.16$). When isolating mothers with moderate–severe symptoms of PND, this result became significant, with a faster improvement in symptoms in the singing group ($p = 0.033$).
Field, 2009, 19761951	Depressive disorders (SCID)	Antenatal/ Prenatal	IPT + Massage (N= NR)	IPT (N =NR)	The group who received both therapies also showed a greater decrease in depression, depressed affect and somatic vegetative symptom scores on CES-D, a greater decrease in anxiety scale (STAI) scores and a greater decrease in cortisol levels.

Study	Mental Health Condition (Inclusion Criteria)	Perinatal Period	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
Field, 2013, 23727060	Depressive disorders (NR)	Antenatal/ Prenatal	IPT (N=22)	Peer support (N= 22)	Both groups had lower summary depression (CES-D) scores and lower anxiety (STAI) scores by the end of the treatment period. Cortisol levels decreased for both groups after the last day session, although the decrease was greater for the peer support group. The groups did not differ on neonatal outcomes including gestational age and birthweight.
Field, 2013, 24138994	Depressive disorders (SCID)	Antenatal/ Prenatal	Yoga (N =46)	Peer support group (N= 46)	No significant difference in anxiety, depression, anger and quality of relationship scores between yoga and peer support at the end of treatment.
Gjerdingen, 2013, 23799688	Depression (PHQ-9 \geq 10)	Postpartum/ Postnatal	Postpartum doula support (N=12), Peer telephone support (N=12)	TAU (N=14)	The postpartum doula group, compared with the other 2 groups, had a higher proportion of women with a previous history of depression, and similarly, a higher proportion of women who were depressed and receiving depression treatment at the 6-month follow-up. Satisfaction with study-sponsored support was greater in the postpartum doula group than in the telephone support group.
Hamilton, 2021, 32997871	Depression and Anxiety (HADS >10)	Antenatal/ Prenatal	Cognitive analytic therapy + TAU (N= 20)	TAU (N= 19)	Mean STAT state score was lower in CAT + TAU group compared to TAU at 24 weeks after randomization. Patient retention was high for the CAT group.
Heller, 2020, 32202505	Depression or Anxiety (CES-D: 16, HADS \geq 8)	Perinatal/ Peripartum	Problem solving therapy (N=79)	TAU (N=80)	Both groups showed a substantial decrease in affective symptoms on the CES-D, HADS-A, and EPDS over time. In the intervention group, affective symptoms decreased more than that in the control group. Negative perinatal child outcomes did not differ between the 2 groups.
Horwitz, 2015, 25452159	Depression, Anxiety, PTSD (BDI \geq 20, BAI \geq 16)	Postpartum/ Postnatal	CBT (trauma focused) (N=62)	Psychoeducation (N=43)	The perceptions of infants' vulnerability showed significant declines, with no differences across groups or in rate of change. Mothers reporting prior trauma at entry to the study showed much lower perceptions of infants' vulnerability scores under the intervention ($p = .01$).
Johnson, 2016, 27003141	Depressive disorders	Postpartum/ Postnatal	IPT (N=25)	Psychoeducation (N=25)	End of treatment satisfaction scores were significantly ($p = .001$) higher in IPT than in

Study	Mental Health Condition (Inclusion Criteria)	Perinatal Period	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
	(SCID)				CWD. Confidence interval around between-groups effect sizes favored IPT for reductions in depressive symptoms during treatment, as well as for improvement in mode-specific targets (social support, grief symptoms) and recovery from posttraumatic stress disorder over follow-up.
Kim, 2019, 30249416	Depressive disorders (SCID, HAM-D ≥ 18)	Antenatal/ Prenatal	transcranial magnetic stimulation (TMS) (N=11)	eSham (N=11)	Right-sided, low frequency TMS was effective in reducing depressive symptoms. Response and remission rates were not significantly different.
Kozinszky, 2012, 22261988	Depressive disorder (Levertton Questionnaire; LQ)	Postpartum/ Postnatal	CBT + IPT + Psychoeducation (N= 93)	TAU (N= 181)	The intervention appeared to significantly reduce the risk of PPD, as defined by Levertton Questionnaire total scores.
Letourneau, 2011, 21385294	Depressive disorders (EPDS >12)	Postpartum/ Postnatal	Peer support (N=27)	TAU (N=33)	A significant difference between the groups was observed for one of the two measures of maternal–infant interactions. Several other measures favored the control group, including mothers’ depressive symptoms and social support scores. No significant treatment effects were observed in infant IQ scores or diurnal salivary cortisol levels in mothers or infants.
Milgrom, 2021, 34889742	Depressive disorders (SCID, EPDS-Anxiety subscale)	Postpartum/ Postnatal	MumMoodBooster (MMB) (N=39), Face to face therapy (N=39)	TAU (N=38)	MMB performed at least as well as face to face CBT (P<0.05). MBB also significantly more effective than face to face CBT in reducing depression. MBB significant effective compared to TAU.
Mitchell, 2012	Depressive disorders (SCID)	Antenatal/ Prenatal	Yoga (N=12)	Psychoeducation(N=12)	The yoga versus control group showed greater decreases on the depressed affect and somatic/ vegetative subscales and the summary score of the Center for Epidemiological Studies Depression Scale.
Ormsby, 2020, 32658830	Depressive disorders (EPDS ≥ 13)	Antenatal/ Prenatal	Acupuncture (N = 19), Progressive Muscle Relaxation (PMR) (N=19)	TAU (N= 19)	There were significantly lower depression scores in the acupuncture group vs TAU and PMR respectively (p = <0.001). Lower acupuncture score for stress (p = 0.006), and psychological distress (p <0.001) when compared to PMR and TAU.
Pan, 2023, 37525110	Depressive, anxiety and stress disorder	Antenatal/ Prenatal	Mindfulness (N=51)	Control (N=51)	Prenatal mindfulness intervention group experienced reduced prenatal stress, anxiety,

Study	Mental Health Condition (Inclusion Criteria)	Perinatal Period	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
	(EPDS \geq 10, PRT, PSS-10)				and depression and reduced postnatal stress and depression. There was no significant difference between the groups in terms of the quality of mother-infant bonding.
Perkins, 2023, 37270855	Depressive disorder (EPDS >10)	Postnatal/ Postpartum	Online 6-week songwriting intervention (Songs from Home) (N=44)	Waitlist control (N=45)	Intervention group reported significantly lower scores postintervention and at follow-up for loneliness ($P < 0.001$) and postnatal depression ($p < 0.001$) and significantly higher scores at follow-up for social connectedness ($P < 0.001$).
Richter, 2012, 23078196	Stress, Anxiety and/ or Depression (MCID, BDI-IV >20, STAI >36, PDQ > 14)	Antenatal/ Prenatal	CBT + Psychoeducation (N=21)	TAU (N=40)	Subjects in the intervention exhibited a significant post-treatment change in morning cortisol (cortisol awakening response, CAR) in contrast to control subjects. Intervention participants showed a smaller CAR subsequent to the intervention, displaying a lessened stress reaction.
Rojas, 2007, 17993363	Depressive disorders (EPDS \geq 10)	Postpartum/ Postnatal	Psychoeducation + clinical monitoring (N=114)	TAU (N=116)	The crude mean EPDS score was lower for the multicomponent intervention group than for the usual care group at 3 months. Although these differences between groups decreased by 6 months, EPDS score remained better in multicomponent intervention group than in usual care group. The decrease in the number of women taking antidepressants after 3 months was greater in the intervention group than in the usual care group.
Stuart, 2023, 38074280	Depressive disorder (DSM-IV)	Postnatal/ Postpartum	Standard Interpersonal Psychotherapy (S-IPT) (N=69)	Clinician-Managed Interpersonal Psychotherapy (CM-IPT) (N=71)	Both CM-IPT and S-IPT were highly efficacious with similar outcomes by 12 weeks, but CM-IPT group utilized significantly fewer sessions. Both were superior to a waitlist control. Superiority comparisons at 12 months did not favor the CM-IPT condition.
Spinelli, 2003, 12611838	Depressive disorder (DSM-IV)	Antenatal/ Prenatal	Interpersonal Psychotherapy (IPT) (N=21)	Didactic parenting education program (N=17)	IPT group showed significant improvement compared to the parenting education control program on all three measures of mood (EPDS, BDI, the Hamilton Depression rating Scale) at termination. Recovery criteria were met in 60% of the women treated with IPT (CGI score of ≤ 2).

Study	Mental Health Condition (Inclusion Criteria)	Perinatal Period	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
Suchan, 2022, 36066958	Depression or Anxiety (EPDS ≥ 10 , GAD-7 ≥ 9)	Postpartum/ Postnatal	CBT + Psychoeducation (N=30)	TAU (N=33)	The ICBT group experienced larger improvements after treatment and at the 1-month follow-up on more measures than the TAU group, with medium between-group Cohen d effects on primary outcome measures for anxiety, PPD and depression, and on secondary outcome measures of overall distress, anxiety, and stress. Time-by-group interactions for proportional reductions between groups over time were only significant after treatment and at the 1-month follow-up for the primary anxiety measure ($p=.006$).
Van Horne, 2022, 34866254	Depressive disorders (EPDS 10-20)	Postpartum/ Postnatal	Problem solving therapy (N=72)	TAU (N=46)	All participating mothers had significant decreases in PPD symptoms. The change in PPD symptoms among those in the home visitation program was not significantly different from the change in the control condition, indicating that the home visitation program was as effective as psychiatric treatment in significantly reducing PPD symptoms. A high proportion of women in the home visitation program completed visits and demonstrated increased maternal self-efficacy.
Vigod, 2019, 31257092	Depressive disorders (DSM IV revised)	Antenatal/ Prenatal	Transcranial direct current stimulation (tDCS) (N=10)	Sham (N=10)	Views of treatment were positive with no serious adverse events. Post-treatment estimated marginal mean MADRS scores were lower for tDCS compared to sham ($p = 0.34$). At 4 weeks postpartum, higher remission rate in for tDCS compared to sham ($p = 0.04$).
Wisner, 2017, 28796940	Depressive disorders (SCID, EPDS ≥ 10)	Postpartum/ Postnatal	DCM (telephone-delivered) (N = 312)	EUC (N=316)	Mean depressive symptom and function scores significantly improved (by greater than 50%) in both groups of women but did not differ by DCM versus EUC assignment. Health services use was similar in women randomly assigned to DCM compared to EUC. Women with childhood sexual abuse responded significantly more favorably to DCM on depression and functional measures (all P values $< .02$).

Abbreviations: BDI = Beck Depression Inventory, BAI = the Beck Anxiety Inventory, CBT=cognitive behavioral therapy, CES-D=Center for Epidemiological Studies Depression Scale, DCM= depression care management, EPDS = Edinburgh Postnatal Depression Scale, EUC=enhanced usual care, GAD= Generalized Anxiety Disorder, HAM-D= Hamilton

Depression Rating Scale, IPT = Interpersonal therapy, MCID=Munich-Composite International Diagnostic Interview, MINI= Mini-Neuropsychiatric Interview, PPD= postpartum depression, SCID= The Structured Clinical Interview for DSM-5, STAT= State–Trait Anxiety Inventory, TAU = treatment as usual, NR not reported

Table C-2. KQ 2: Evidence map

Study	Population (Disorder)	Population (Perinatal Period)	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
Milgrom, 2015, 25586754	Depression and Anxiety (DSM IV revised, EPDS)	Postpartum/ Postnatal	CBT (N=14)	SSRI (N=15), CBT+SSRI (N=16)	CBT monotherapy was found to be superior to both SSRI monotherapy and CBT+SSRI combination therapy after 12 weeks.
Sharp, 2010, 20860888	Depressive disorders (ICD-9, CIS-R, EPDS ≥13)	Postpartum/ Postnatal	Antidepressant (SSRI recommended) (N=129)	Non-directive counseling (N=125)	There was no statistically significant difference in depression symptoms at the end of treatment between the antidepressant and counseling groups.

Abbreviations: CBT=cognitive behavioral therapy, CES-D=Center for Epidemiological Studies Depression Scale, EPDS = Edinburgh Postnatal Depression Scale, SSRI= selective serotonin reuptake inhibitors, CIS-R = clinical interview schedule, ICD-9 = international classification of diseases

Table C-3. Design details

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Alhusen, 2021, 32409986	United States	NR	Reported (No COI)	Age: ≥16, EPDS (Full) >12, <12 weeks gestation at the time of enrollment, English-speaking	Depressive disorders	Antenatal/ Prenatal	2	60
Amani, 2021, 34758210	Canada	Non-Industry	Reported (No COI)	Age: ≥18, had an infant < 12 months of age, EPDS (Full) ≥10, fluent in English, free of bipolar, psychotic, or current substance use disorders per the Mini-International Neuropsychiatric Interview (MINI).	Depressive disorders	Postpartum/ Postnatal	2	73
Ammerman, 2013, 23768664	United States	Non-Industry	NR	Age: ≥16, Structured diagnostic criteria/diagnostic tool: SCID, EPDS (Full) ≥11.	Depressive disorders	Postpartum/ Postnatal	2	93
Armstrong, 2003, 12956024	Australia	NR	NR	EPDS (Full) ≥12, Child aged between 6 wks to 12months. Able to complete aerobic exercise according to Physical Activity Readiness-Questionnaire.	Depressive disorders	Postpartum/ Postnatal	2	20
Bais, 2020, 33115894	Netherlands	Non-Industry	Reported (yes COI)	Age: 18–45, Structured diagnostic criteria/diagnostic tool: DSM V SCID, 12–32 weeks pregnant (as confirmed by ultrasound)	Depressive disorders	Antenatal/ Prenatal	2	67
Bittner, 2014, 25062520	Germany	Non-Industry	Reported (No COI)	Age: >18 yr, Structured diagnostic criteria/diagnostic tool: Munich-Composite International Diagnostic Interview, screening results of at least 1 questionnaire (PDQ >14 and/or STAI >36 and/or BDI-V >20), capable of reading German.	Depression or Anxiety	Antenatal/ Prenatal	2	118
Broberg, 2021, 32862425	Denmark	Non-Industry	Reported (No COI)	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM V, Danish speaking; singleton pregnancy;	Depressive disorders	Antenatal/ Prenatal	2	282

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Burger, 2020, 31806071	Netherlands	Non-Industry	NR	Structured diagnostic criteria/diagnostic tool: DSM IV revised SCID, EPDS (Full) ≥ 12 , STAI ≥ 42	Depression or Anxiety	Antenatal/Prenatal	2	282
Burns, 2013, 23339584	United Kingdom	Non-Industry	Reported (No COI)	Age: >16 , Structured diagnostic criteria/diagnostic tool: CIS-R, were between 8 and 18 weeks pregnant and who screened positive on a 3-question depression screen	Depressive disorders	Antenatal/Prenatal	2	36
Buttner, 2015, 25886805	United States	NR	Reported (No COI)	Age: 18-45, Structured diagnostic criteria/diagnostic tool: DSM-IV Axis-I Disorders (SCID-I), HAM-D ₁₇ ≥ 12 , PHQ-9 ≥ 10 , ≥ 6 weeks PP if delivery was either complicated and/or involved a cesarean section residence within a 30-mile radius of the yoga studios.	Depressive disorders	Postpartum/Postnatal	2	57
Canfield, 2023, 37853333	United States	Non-industry	Reported (No COI)	Structured diagnostic criteria/diagnostic tool: GAD-7 score ≥ 10 or PHQ-9 score ≥ 10 . Cohabiting with current partner, living in Missouri, and with internet access.	Depressive and/or anxiety disorders	Antenatal/Prenatal	2	30
Challacombe, 2017, 28137316	United Kingdom	Non-Industry	Reported (No COI)	Structured diagnostic criteria/diagnostic tool: DSM IV revised SCID	Obsessive-compulsive disorder	Postpartum/Postnatal	2	34
Chiorino, 2020, 31805778	Italy	Non-Industry	Reported (No COI)	Age: 18, score 24 on the (IES-R), having experienced a traumatic childbirth in the previous hours or at 3 most three days before (both objective and subjective traumatic childbirth-related experiences, fluent Italian language; legal capacity to consent to the treatment.	Post-traumatic stress disorder	Postpartum/Postnatal	2	37

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Cho, 2008, 18729297	South Korea	NR	NR	Structured diagnostic criteria/diagnostic tool: DSM IV revised SCID-IV-I, BDI >16, pregnant, consented to participate	Depressive disorders	Antenatal/ Prenatal	2	27
Chung, 2012, 22840621	Hong Kong	Non-Industry	Reported (No COI)	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM IV revised, EPDS (Full) ≥12, HDRS ₁₇ 12-19, ethnic Chinese and permanent residents in Hong Kong; within 6 mo of giving birth.	Depressive disorders	Postpartum/ Postnatal	2	20
Cooper, 2003, 12724244	United Kingdom	Non-Industry	Reported (No COI)	EPDS (Full) ≥12, primiparous, living within a 15-mile radius of the maternity hospital and with English as their first language	Depressive disorders	Postpartum/ Postnatal	4	190
Da Costa, 2009, 19728220	Canada	Non-Industry	NR	In the PP period (4–38 weeks), EPDS (Full) ≥10, English/French comprehension; no substance abuse; not currently in exercise program; no obstetrical or concomitant diseases precluding participation in exercise	Depressive disorders	Postpartum/ Postnatal	2	88
Daley, 2008, 18399022	United Kingdom	Non-Industry	Reported (No COI)	Age ≥ 16, EPDS (Full) > 12, whose youngest child < 12 months' old.	Depressive disorders	Postpartum/ Postnatal	2	38
Daley, 2015, 25804297	United Kingdom	Non-Industry	Reported (No COI)	Age: ≥ 18, Structured diagnostic criteria/diagnostic tool: ICD-10 (WHO), EPDS ^a (EPDS2 ≥13) and clinical diagnostic interview (CIS-R), within 6 mo of given birth.	Depressive disorders	Postpartum/ Postnatal	2	94

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Danaher, 2023, 36174746	United States	Non-Industry	Reported (No COI)	Age ≥ 18 , EPDS (Full) > 12 , pregnant or <1 year PP, no active suicidal ideation, access to broadband internet via desktop/laptop, tablet, or smartphone, and English language proficiency.	Depressive disorders	Perinatal/ Peripartum	2	191
Dennis, 2020, 32029010	Canada	Non-Industry	Reported (No COI)	Age: >18 , Structured diagnostic criteria/diagnostic tool: SCID, EPDS (Full) >12 , English-speaking; between 2- and 24-weeks PP, and discharged home from hospital with their infant.	Depressive disorders	Postpartum/ Postnatal	2	241
Dimidjian, 2017, 28045285	United States	Non-Industry	Reported (yes COI)	Age: ≥ 18 , PHQ-9 ^b ≥ 10 , English speaker, receiving care at one of the participating sites, no known diagnosis of bipolar disorder, psychotic disorder, active substance dependence, or immediate risk of self-harm or need for hospitalization	Depressive disorders	Antenatal/ Prenatal	2	163
Donmez, 2022, 35339911	Turkey	NR	Reported (No COI)	Age: 18–45, Structured diagnostic criteria/diagnostic tool: DSM V, EPDS (Full) ≥ 12 , ability to read, understand, and sign the informed consent form and understand study procedures, pregnant or in the first year PP.	Depressive disorders	Antenatal/ Prenatal Postpartum/ Postnatal	2	30
Field, 2013, 23337557	United States	Non-Industry	Reported (No COI)	Age < 40 , Structured diagnostic criteria/diagnostic tool: DSM IV revised SCID, being pregnant with one child; an uncomplicated pregnancy with no medical illness; not using drugs (i.e., prescribed or illicit).	Depression and Anxiety	Antenatal/ Prenatal	2	92

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Forsell, 2017, 28628768	Sweden	Non-Industry	Reported (No COI)	Age: ≥18, gestational week 11-28. Structured diagnostic criteria/ diagnostic tool: SCID-I, MADRS-S 15-35, only women with no or a low risk of suicide as indicated by a score of 4 or less on item 9 on MADRS-S and the clinician's assessment during the semi-structured telephone interview. able to use the internet for the ICBT	Depressive disorders	Antenatal/ Prenatal	2	42
Forsyth, 2017, 28278021	United Kingdom	NR	NR	Structured diagnostic criteria/diagnostic tool: DSM-IV SCID, EPDS (Full) ≥12 at women routine visit 6 weeks' PP.	Depressive disorders	Postpartum/ Postnatal	2	22
Gamble, 2005, 15725200	Australia	Non-Industry	NR	Age: >18, 3rd trimester; live birth expected. Structured diagnostic criteria/diagnostic tool: criterion A of DSM-IV-TR.	Post-traumatic stress disorder	Postpartum/ Postnatal	2	103
Green, 2020, 31957479	Canada	Non-Industry	Reported (No COI)	Age: 18–45, Structured diagnostic criteria/diagnostic tool: DSM IV, for principle anxiety with/no depression using DSM-5 no psychotropic medication or no change in dose and type for a minimum of 6 wks prior to baseline assessment; no changes in psychotropic medication during 6-week CBGT or 6-week waitlist; no concurrent psychological treatment; fluent in English, pregnant or within the first 6mo PP.	Depression and Anxiety	Antenatal/ Prenatal Postpartum/ Postnatal	2	86

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Grote, 2009, 19252043	United States	Non-Industry	Reported (No COI)	Age: ≥ 18 . EPDS (Full) >12 , range (0-30), 10 to 32 wks gestation, English speaking, access to a telephone, and living in the Pittsburgh region	Depressive disorders	Antenatal/ Prenatal	2	53
Hankin, 2023, 37074698	United States	Non-industry	Reported (Yes COI)	Age: 18 to 45 years, Structured diagnostic criteria/diagnostic tool: EPDS score ≥ 10 , DSM-5 [SCID-5], English speaking, 25 weeks' gestational age or less, singleton pregnancy	Depressive disorders	Antenatal/ Prenatal	2	234
Hayden, 2012, 22526914	United States	Non-Industry	Reported (No COI)	Age: 15-44, Structured diagnostic criteria/diagnostic tool: DSM-IV, DIS, preexisting diabetes (type 1 or type 2 or gestational) requiring insulin during pregnancy	Depressive disorders	Antenatal/ Prenatal	2	34
Honey, 2002, 12437794	United Kingdom	Non-Industry	NR	EPDS (Full) >12 , <12 mo PP	Depressive disorders	Postpartum/ Postnatal	2	45
Huh, 2023, 37498661	Canada	NR	NR	Age: 18 or older. Structured diagnostic criteria/diagnostic tool: EPDS score ≥ 10 , and infant under the age of 12 months.	Depressive disorders	Postpartum/ Postnatal	2	136
Husain, 2023, 37413896	United Kingdom	Non-Industry	Reported (yes COI)	Age ≥ 16 , Structured diagnostic criteria/diagnostic tool: ICD-10, living with their babies, having a child up to 12 months of age, British women of South Asian origin as defined by UK Office of - National Statistics,	Depressive disorders	Postpartum/ Postnatal	2	83

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Lenze, 2017, 28038377	United States	NR	NR	Age: ≥ 18 . Structured diagnostic criteria/diagnostic tool: DSM IV revised SCID, EPDS (Full) ≥ 10 . Pregnant between 12–30 wks gestation, singleton pregnancies.	Depressive disorders	Antenatal/ Prenatal	2	42
Leung, 2016, 26908335	Hong Kong	Non-Industry	NR	Age ≥ 18 . Structured diagnostic criteria/diagnostic tool: DSM IV revised, EPDS (Full) ≥ 10 , HADS (anxiety subscale) HADS (depression subscale), Hong Kong Chinese PP women, at 6 to 8 weeks after delivery, living with their husband,	Depressive disorders	Postpartum/ Postnatal	2	164
Loughnan, 2019, 30266030	Australia	Non-Industry	Reported (No COI)	Age > 18 , completed brief online screening questionnaire, Australian resident; had computer and internet access; between 13 and 30 weeks pregnant.	Depression and Anxiety	Antenatal/ Prenatal	2	87
Loughnan, 2019, 30877878	Australia	Non-Industry	Reported (No COI)	Age > 18 , GAD-7 and/or PHQ-9 ≥ 10 , within 12 months PP, Australian resident; computer and internet access;	Depression and Anxiety	Postpartum/ Postnatal	2	131
Madigan, 2015, 25703488	Canada	Non-Industry	NR	Age: 12-18 . Structured diagnostic criteria/diagnostic tool: Adult Attachment Interview (AAI) criteria (for an unresolved state of mind) or CPTSDI, having a score that fell above the clinical cutoff for dissociation; 12-23 weeks of pregnancy, planning to keep the baby, fluent in English	Post-traumatic stress disorder	Antenatal/ Prenatal	2	43

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Manber, 2004, 15546651	United States	Non-Industry	NR	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM IV revised, HRSD ₁₇ ≥14, 11-28wk gestation; receiving prenatal care in the community.	Depressive disorders	Antenatal/ Prenatal	3	61
Manber, 2010, 20177281	United States	Non-Industry	Reported (No COI)	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM-IV-TR revised, HADS ₁₇ ≥14, 12 and 30wk gestation	Depressive disorders	Antenatal/ Prenatal	3	150
Mennen, 2021, 33221606	United States	Non-Industry	Reported (No COI)	Structured diagnostic criteria/diagnostic tool: CES-D >8	Depressive disorders	Postpartum/ Postnatal	2	119
Merza, 2023, 37649448	Canada	Non-industry	Reported (No COI)	Age: 18 or older. Structured diagnostic criteria/diagnostic tool: EPDS score ≥10, and infant under the age of 12 months.	Depressive disorders	Postpartum/ Postnatal	2	183
Milgrom, 2005, 16368032	Australia	Non-Industry	NR	Structured diagnostic criteria/ diagnostic tool: DSM IV revised, EPDS (Full), 37–42wk pregnancy; infant BW 2.5 kg and above, no congenital abnormality; no major health problem, and no concurrent major psychiatric disorder.	Depressive disorders	Postpartum/ Postnatal	4	192
Milgrom, 2011, 21615968	Australia	Non-Industry	Reported (No COI)	Age ≥18, EPDS ≥ 13, women with infant aged 6 weeks to 4 months.	Depressive disorders	Postpartum/ Postnatal	3	68
Milgrom, 2015, 25709044	Australia	Non-Industry	Reported (No COI)	Structured diagnostic criteria/diagnostic tool: DSM-IV, EPDS ≥ 13 (referred to interview), <30wk pregnancy	Depressive disorders	Antenatal/ Prenatal	2	54
Milgrom, 2016, 26952645	Australia	Non-Industry	Reported (No COI)	Age ≥18, Structured diagnostic criteria/diagnostic tool: DSM-IV SCID, EPDS (Full) 11-23 (screening criteria) ^c	Depressive disorders	Postpartum/ Postnatal	2	43

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Mulcahy, 2010, 19697094	Australia	Non-Industry	NR	Structured diagnostic criteria/ diagnostic tool: DSM IV revised, an infant aged ≤12 months	Depressive disorders	Postpartum/ Postnatal	2	57
Ngai, 2015, 26278623	Hong Kong	Non-Industry	Reported (No COI)	Age ≥18, EPDS (Full) ≥ 10, married, primiparous, Hong Kong residents, able to speak and read Chinese, giving birth to a single full-term healthy baby ^d	Depressive disorders	Postpartum/ Postnatal	2	397
Nieminen, 2016, 27152849	Sweden	Non-Industry	Reported (No COI)	Age: ≥18, Structured diagnostic criteria/diagnostic tool: MINI, TES sum score ≥30; having access to a computer and internet, able to read and write Swedish, not pregnant, not having problems requiring urgent care, not currently engaged in psychotherapy care, minimum of three months of traumatic delivery	Post-traumatic stress disorder	Postpartum/ Postnatal	2	56
O'Hara, 2000, 11074869	United States	Non-Industry	NR	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM IV revised (SCID), HAM-D ₁₇ ≥12, completed (IDD), were married or living with a partner for at least 6 months.	Depressive disorders	Postpartum/ Postnatal	2	120
O'Mahen, 2013, 23319454	United Kingdom	Non-Industry	NR	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM-IV, EPDS (Full) ≥12, ≥24wks pregnant, no previous treatment for depression	Depressive disorders	Perinatal/ Peripartum	2	55
O'Mahen, 2013, 23602514	United Kingdom	Non-Industry	Reported (No COI)	Age: ≥18, EPDS (Full) >12, birth within 12 months	Depressive disorders	Postpartum/ Postnatal	2	910

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
O'Mahen, 2014, 24148703	United Kingdom	Non-Industry	Reported (No COI)	Age: >18, Structured diagnostic criteria/diagnostic tool: ICD-10, EPDS (Full) >12, live birth within year; no substance abuse or psychosis; speaking English.	Depressive disorders	Postpartum/ Postnatal	2	83
O'Mahen, 2022, 35177019	United Kingdom	Non-industry	Reported (Yes COI)	Age: 18 or older. Structured diagnostic criteria/diagnostic tool: GAD-7 score ≥ 7 .	Anxiety disorder	Antenatal/ Prenatal	2	114
Okatsau, 2023, 37163508	Japan	Non-Industry	Reported (No COI)	Age: 20 or older. Structured diagnostic criteria/diagnostic tool: 5 to 14 points on the GAD-7, more than 22 weeks pregnant, and able to speak, read and write in Japanese	Anxiety disorder	Antenatal/ Prenatal	2	63
Pearson, 2013, 22884235	United Kingdom	Non-Industry	Reported (No COI)	Age: >16, Structured diagnostic criteria/diagnostic tool: ICD-10 CIS-R, EPDS, 8-18wks pregnant.	Depressive disorders	Antenatal/ Prenatal	2	24
Prendergast, 2001,	Australia	Non-Industry	NR	Structured diagnostic criteria/diagnostic tool: DSM IV revised, EPDS (Full) >12	Depressive disorders	Postpartum/ Postnatal	2	37
Pugh, 2016, 26930488	Canada	Non-Industry	Reported (No COI)	Age: ≥ 18 , Structured diagnostic criteria/diagnostic tool: MINI, EPDS (Full) ≥ 10 , a birth within past year; Saskatchewan resident; not receiving concurrent psychotherapy; if medicated, stable dose for >1mo; no past or present psychotic mental illness, computer and Internet access,	Depressive disorders	Postpartum/ Postnatal	2	50

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Segre, 2015, 25486371	United States	Non-Industry	NR	Age: ≥14, Structured diagnostic criteria/diagnostic tool: DSM IV revised, Nonpatient Edition (SCID-I/NP), EPDS (Full) ≥12, were English or Spanish speaking, were not currently receiving counseling services although medication management was permitted	Depressive disorders	Antenatal/ Prenatal Postpartum/ Postnatal	2	66
Shaw, 2014, 25049338	United States	Non-Industry	Reported (No COI)	Age: >18, infants aged 25 to 34wks ^e , score > the clinical cutoff on 1 of 3 screening instruments administered at baseline: BAI, SASRQ, BDI-II (BAI ≥16 SASRQ ≥3, BDI-II ≥20), English- or Spanish-speaking.	PTSD, anxiety, depression	Postpartum/ Postnatal	2	105
Stein, 2018, 29413138	United Kingdom	Non-Industry	Reported (No COI)	Age: ≥18. Structured diagnostic criteria/diagnostic tool: DSM IV revised, full diagnostic criteria, infant born at 35 or more weeks, BW ≥2000g, 4.5-9mo old, and with no serious complications.	Depressive disorders	Postpartum/ Postnatal	2	144
Toth, 2013, 24229549	United States	Non-Industry	NR	Age: 18-40, Structured diagnostic criteria/diagnostic tool: DSM IV revised, BDI-II ≥19, CES-D >16, reside at or below the federal poverty level, with a 12-month-old infant.	Depressive disorders	Postpartum/ Postnatal	2	128
Trevillion, 2020, 31634678	United Kingdom	Non-Industry	Reported (yes COI)	Age: ≥16, Structured diagnostic criteria/diagnostic tool: DSM IV revised, pregnant (not exceeding 26wks gestation)	Depressive disorders	Antenatal/ Prenatal	2	53

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Upshur, 2016, 27480668	United States	Non-Industry	NR	Age: 18, Primary care PTSD Screen ≥ 2 , initiated prenatal care before 27 weeks gestation, spoke English, Spanish, Vietnamese, or Portuguese.	Post-traumatic stress disorder	Antenatal/ Prenatal	2	149
Van Lieshout, 2021, 34495285	Canada	Non-Industry	Reported (No COI)	Age: ≥ 18 , EPDS (Full) ≥ 10 , infant younger than 12mo	Depressive disorders	Postpartum/ Postnatal	2	403
Van Lieshout, 2022, 35060398	Canada	Non-Industry	Reported (No COI)	Age: ≥ 18 , EPDS (Full) ≥ 10 , had an infant < 12 mo	Depressive disorders	Postpartum/ Postnatal	2	141
Van Lieshout, 2023, 36878891	Canada	Non-Industry	Reported (No COI)	Age: ≥ 18 or older, EPDS (Full) ≥ 10 , infant younger than 12mo	Depressive disorders	Postpartum/ Postnatal	2	461
Vigod, 2021, 33949762	Canada	Non-Industry	Reported (yes COI)	Age: ≥ 18 , EPDS (Full) ≥ 10 , an infant between 0 and 12 months old, Reside in Ontario.	Depressive disorders	Postpartum/ Postnatal	2	98
Wiklund, 2010, 20636249	Sweden	Industry	Reported (No COI)	EPDS (Full) ≥ 12 , Women with healthy newborns, who had an instrumental delivery or an emergency cesarean section, were therefore chosen as the study group.	Depressive disorders	Postpartum/ Postnatal	2	67
Wirz-Justice, 2011, 21535997	Switzerland	Non-Industry	Reported (yes COI)	Age: 18-45. Structured diagnostic criteria/diagnostic tool: DSM IV revised, EPDS (Full) ≥ 10 , SIGH-ADS ≥ 20 . Pregnancy 4 through 32wks gestation, medically healthy, with normal ocular function.	Depressive disorders	Antenatal/ Prenatal	2	46
Wozney, 2017, 28593360	Canada	Non-Industry	Reported (yes COI)	Age: 19-45, Structured diagnostic criteria/diagnostic tool: DSM-IV-TR Axis I Disorders SCID-I, 1-12 mo PP, live in Nova Scotia, access to a telephone, if medicated, should be stable for the 4 weeks prior to study	Depressive disorders	Postpartum/ Postnatal	2	62

^aWomen who scored on first EPDS1 then completed a second EPDS2 2 weeks later by telephone to rule out the possibility of transient depression. Women who scored 13+ on the EPDS-2 then completed the Clinical Interview Schedule-Revised (CIS-R). ^bExpanded from the initial plan to require ≥ 15 given clinical guidelines in the delivery settings that recommended additional screening and intervention for such patients), ^cAnother screening criteria: Australian residency, Internet access with regular email use, < than 1 year PP, d(gestation between 37 and 41 weeks; body weight >2.5 kg; APGAR score at 5 min >7), eweighing 600 g and born at or transferred to NICUs within the first week of delivery,

Abbreviation; MINI: Mini-Neuropsychiatric Interview, PDQ= Prenatal Distress Questionnaire, STAI = State-Trait Anxiety Inventory, BDI = Beck Depression Inventory, PP = post-partum, IES-R = Impact of Event Scale-Revised, HDRS17 = 17-item Hamilton Rating Scale for Depression, MDD = Major depressive disorder, MADRS-S = Montgomery-Asberg Depression Rating Scale- Self report version, PHQ-9; Patient health questionnaire, BW = birth-weight, TES = Traumatic Events Scale, IDD = Inventory to Diagnose Depression, BAI = the Beck Anxiety Inventory, SASRQ = Stanford Acute Stress Reaction Questionnaire, SIGH-ADS = Structured Interview Guide for the Hamilton Depression Rating Scale (HAMD) with Atypical Depression Supplement, DSM-IV-TR = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised, DIS = National Institute of Mental Health Diagnostic Interview Schedule

Table C-4. Baseline characteristics

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Alhusen, 2021, 32409986	CBT (30) TAU (30)	24.5 (5.5)	White or Caucasian: 10 Black or African: 90	7th-9th grade: 20. 10th-12th grade: 33. HS grad/GED: 38 Some college/college degree: 6	Unemployed: 76 Employed, part-time: 7. Employed, full-time: 17	NR
Amani, 2021, 34758210	CBT (Peer-delivered group CBT) (37) TAU (Waitlist group) (36)	31.6 (4.7)	White or Caucasian: 94.3 Other: 5.6	Education (y): mean (SD) 14.6 (1.6)	NR	Married/common-law: 92 Single: 8
Ammerman, 2013, 23768664	CBT (47) TAU (46)	22 (4.6)	White or Caucasian: 62.3 Black or African: 32.4 Bi-racial: 2.2 Other: 4.2	Educational (years) mean (SD) 11.5 (1.5)	NR	Married: 12.9 Single never married & separated: 87.1
Armstrong, 2003, 12956024	Exercise (10) TAU (10)	The majority ^a were between 21-30	NR	NR	The majority were ^a homemakers	Married/de facto relationship 100
Bais, 2020, 33115894	Bright light therapy (33) Dim light therapy (Dim red-light therapy) (34)	31.9 (4.85)	Dutch: 79.1 Other: 20.9	Elementary or (pre-) vocational education: 35.8, Higher professional education: 28.4, (Pre-)academic education: 35.9	NR	Married or cohabiting: 97.1 Single: 0.5
Bittner, 2014, 25062520	CBT (39) TAU (79)	29.6 (4.2)	NR	Ninth grade 0.95 Tenth grade 19.4 High school (12th grade) 84.7 Other 10	Unemployed 6.3 Employed 93.8	Married: 43.2

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Broberg, 2021, 32862425	Exercise (143) TAU (139)	29.5 (3.9)	NR	Advanced degree: 51.8 3-4 y higher education: 30.9 1-2 y higher education: 5 Skilled workers: 4.3 Compulsory education: 7.4	Employed: 65.2 Unemployed: 12.4 Student: 18.8 Other: 0.04	Living with partner: 95.4
Burger, 2020, 31806071	CBT (140) TAU (142)	32.8 (4.6)	White or Caucasian: NR Black or African (Black and minority ethnic) 4.1 Asian: NR Hispanic or Latinx: NR	NR	NR	Marital status single: 8.1
Burns, 2013, 23339584	CBT (CBT + TAU) (18) TAU (18)	29.2 (5.6) range 20-41	White or Caucasian: 83.3 Other races: NR	'O' level or equivalent and above) 86.1	Working (full or part time) 58.4	Married/ living as married 63.9
Buttner, 2015, 25886805	Yoga/ Tachi (28) TAU (29)	31.2 (5.0)	White or Caucasian: 89.5 Non-Hispanic: 93 Black or African: NR Asian: NR Hispanic or Latinx: NR Other: NR	Mean years of education 16.8 (2.27)	Employed: 66	Married: 79
Canfield, 2023, 37853333	CBT (15) TAU (15)	31.0 (7.80)	White or Caucasian: 76.5 Black: 23.5	Completed college: 55	Employed: 88	With current partner: 98.5
Challacombe, 2017, 28137316	CBT (17) TAU (17)	32.6 (NR)	White or Caucasian: 85 Other races: NR	to degree level or above 67.5	NR	With partner 99

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Chiorino, 2020, 31805778	EMDR (Eye Movement Desensitization and Reprocessing) (19) TAU (18)	34.4 (5.6)	NR	Low secondary school 10.8 High secondary school 29.7 Degree 59.5	Unemployed 18.9 Employed 62.2 other 18.9	Married / Cohabiting: 97.3 Single 2.7
Cho, 2008, 18729297	CBT (12) TAU (15)	29.6 (3.4)	NR	High school 54.5 College 40.9 Graduate School 4.5	Housewife 63.6 Working wife 36.4	NR
Chung, 2012, 22840621	Acupuncture (10) Sham Acupuncture (10)	34.9 (3.6)	Asian: 100% Other races: 0.0	Full-time education in year, mean (SD): 12.0 (3.7)	Employed: 85	Married/cohabiting: 80 Single/Divorced/widowed: 20
Cooper, 2003, 12724244	Counseling (48) CBT (42) Psychodynamic (48) TAU (Routine primary care) (52)	27.7 (5.4) Range: 17-42	NR	None/CSE/'O' level/GSCE 45.3 'A' level/further qualification 31 Degree/higher degree 23.5	NR	Married/co-habiting 88 Single/divorced/widowed 12
Da Costa, 2009, 19728220	Exercise (46) TAU (42)	33.5 (4.1)	White or Caucasian: 78.3 Other races: NR	Education (years) Mean (SD) 15.6 (2.2)	NR	NR
Daley, 2008, 18399022	Exercise (47) TAU (47)	Range (%) 21-30: 52.6 31-40: 44.7 >40: 2.6	White or Caucasian: 73.7 Other races: NR	NR	Paid 68.4 Unemployed 10.5 Looking after family/home 15.8 Sick disabled 2.6	Married/with Partner: 76.3

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Daley, 2015, 25804297	Exercise (47) TAU (47)	30.5 (5.5)	White or Caucasian: 62.8 Black or African: 3.2 Black-Caribbean: Asian: 21.3 Mixed: 5.3 Hispanic or Latinx: NR Other: 6.4	NR	Paid 45 Self-employed 2 Unemployed 13 Student 3 Looking after home/family 35.5	Living with husband 88
Danaher, 2023, 36174746	CBT (96) TAU (95)	31.9 (5.2)	White or Caucasian: 67.4 Black or African: 8.0 Asian: 14.5 Hispanic or Latinx: 12.4 Other: 10.2	Less than high school 1.1 High school graduate 15.2 GED 1.6 Associate degree or Trade School 7.4 Bachelor's degree 33 Master's or other graduate degree 34.1 Doctoral or postgraduate degree 7.9	NR	Married or in long-term relationship: 94.2. Single: 5.8
Dennis, 2020, 32029010	IPT (120) TAU (121)	30.6 (6.0)	Canadian: 51.7 Other: 48.2	Elementary 7.8 High school 17 College 30.7 Undergraduate university 32.8 Graduate university 11.6	NR	Married/common-law marriage: 92.6
Dimidjian, 2017, 28045285	CBT (86) TAU (77)	28.8 (5.7)	White or Caucasian: 58.3 Black or African: 27.6 Asian: 4.3 Hispanic or Latinx: 15.3 Other: 9.82	< High school 7.4 High school 23.9 Some college 36.2 College 19.02 Graduate school 13.5	Employed full- or part-time 70.6	Married/ cohabiting: 69.9 Single never married and Divorced/ separated: 30.1

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Donmez, 2022, 35339911	Bright light therapy (15) placebo (15)	28.87 (5.35)	NR	Primary School 43.3 High School 33.3 University 23.3	NR	Married: 96.7 Divorced: 3.3
Field, 2013, 23337557	Yoga/ Tachi (46) TAU (46)	25.2 (5.2)	White or Caucasian: 2.5 Black or African: 39 Asian: NR Hispanic or Latinx: 58.5	Mean (SD) 4.1 (2.7)	NR	Married: 17.5 Single: 35 Boyfriend 47.5
Forsell, 2017, 28628768	CBT (Internet delivered CBT) (22) TAU ^b (20)	31 (4.5)	NR	High school: 27 University: 73	Working or self-employed: 78.5 Sick leave: 17 Unemployed: 5 Maternity leave: 12	In a committed relationship: 98
Forsyth, 2017, 28278021	Exercise (11) TAU (11)	26.0 (5.3)	NR	University undergraduate degree: 9.1 Left school at 18: 31.8. Left school at 16: 59.1	Full time 59.1 Part-time 4.5 Unemployed 40	Married/living with partner: 77.3. Never married: 22.7
Gamble, 2005, 15725200	Counseling (Not directive) (50) TAU (53)	28 (6.04)	White or Caucasian: 93.2 Black or African: NR Asian: 1.0 Hispanic or Latinx: NR Other: 2.9	Secondary education 60.2 Tertiary study 35.9 Higher degree 3.9	NR	Married/de facto: 85.4 Single/Separated/divorced : 14.6
Green, 2020, 31957479	CBT group format) (44) TAU (Waitlist) (42)	31.9 (3.6)	White or Caucasian: 90.7 Black or African: 1.2 Asian: 1.2 Hispanic or Latinx: 2.4 Other: 4.6	High school 9.3 Certificate/professional diploma 31.4 Bachelor's degree 37.3 Post-graduate degree (MA, PhD, MD) 22.1	NR	Married/common-law: 91.9 Single: 8.1

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Grote, 2009, 19252043	IPT (25) TAU (28)	24.5 (5.5)	White or Caucasian: 28 Black or African: 62.3 Asian: NR Hispanic or Latinx: 4 Other: 5.7	Less than high school 13, High school degree 26.4, GED 11 Vocational degree or some college 45.2, College or graduate degree 9	Full-time 15 Part-time 21 Unemployed 64	Married 7.5 Cohabiting 32 Divorced separated or widowed 11.5 Never married 49:
Hankin, 2023, 37074698	IPT (115) TAU (119)	29.9 (5.9)	Asian: 4.3% Black: 9.4% Hispanic: 18.4% Native Hawaiian/ Pacific Islander: 0.4% Non-Hispanic White: 43.2% Multiracial or multiethnic: 24.8%	<High school: 5.5% High school: 19.2% Some college: 29.9% College degree: 29.5% Graduate degree: 15.8%	NR	Cohabiting with partner: 74.4%
Hayden, 2012, 22526914	CBT (20) Counseling (14)	30.7 (5.0)	NR	NR	NR	NR
Honey, 2002, 12437794	CBT (23) TAU (22)	27.9 (5.52)	NR	NR	NR	married or cohabiting: 78
Huh, 2023, 37498661	CBT (71) TAU (65)	31.5 (4.85)	Non-white: 20.5	Mean years of education 14.85 (SD 1.75)	NR	Married/common-law: 91
Husain, 2023, 37413896	CPT (42) TAU (41)	30.3 (5.7)	British South Asian ^d : 100	NR	NR	NR

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Lenze, 2017, 28038377	IPT (21) TAU (21)	26.46 (5.9) Range 18-40	White or Caucasian: 16.7 Black or African: 78.6 Asian: 0.0 Hispanic or Latinx: 0.0 Other: 5	Some high school 26.2 High school diploma/GED 23.8 Some college or 2-year degree 38.1 4-year college/graduate degree 11.9	Employed 17 (40.5)	Married/Living in marriage-like relationship: 28.6 Never Married 64.3 Separated/Divorced 9.5:
Leung, 2016, 26908335	CBT (82) TAU (82)	31.2 (4.7)	Asian ^c 100	Secondary & below 59.5 Tertiary & above 40.2	Full time work 61.6 Housewife 23.8 Other 9.9	NR
Loughnan, 2019, 30877878	CBT (69) TAU (62)	32.56 (4.53)	NR	No qualification 1 School-level 12 Trade/certificate 14 Diploma 8 Undergraduate 48 Post-graduate 18	Full-time paid work/study 11 Part-time paid work/study 14 At home parent 38 Maternity leave 23 Other 15	In a relationship Married/de facto: 96 Single 3 Separated/Divorced: 1
Loughnan, 2019, 30266030	CBT (43) TAU (44)	31.61 (4.00)	NR	School Level 5 Trade/certificate/diploma 16 University undergraduate degree 60 University post-graduate degree 19	Full time paid work 52 Part-time paid work 31 Full-time student 3 Part-time student 4 At home parent 9 Unemployed 1	In a relationship/de factor or Married: 95 Separated or divorced 1 single: 4
Madigan, 2015, 25703488	CBT (21) TAU (22)	17.0 (0.9)	NR	Years of maternal education (it can be assumed) 10.1 (1.1)	NR	Married/in Relationship: 10.0 Single-Parent Status: 90.0

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Manber, 2004, 15546651	Acupuncture (20) Sham Acupuncture (21) Massage ^d (20)	33.3 (4.7)	Caucasians 75%	93% had at least some college education	NR	NR
Manber, 2010, 20177281	Acupuncture (Specific for Depression) (52) Acupuncture (Not Specific for Depression) (49) Prenatal Massage ^d (49)	32.9 (4.9)	White or Caucasian: 65.2 Black or African: 5.5 Asian: 8.9 Hispanic or Latinx: 17.9 Other: 20.3	High school 3.4 Some college 20.8 College 42.4 Graduate school 32.7	Work 61.2 Student 2.7 Unemployed/homemaker 36.1	NR
Mennen, 2021, 33221606	IPT (49) TAU (70)	32.7 (6.8)	White or Caucasian: 0.8 Black or African: 14.3 Asian: 0.8 Hispanic or Latinx: 80.7 Other: 3.4	Less than high school 38.7 High school diploma 27.7 Some college/trade school 26.1 College degree or higher 7.6	NR	NR
Merza, 2023, 37649448	CBT (92) TAU (91)	31.7 (4.8)	White or Caucasian: 78.9 Other: 21.1	Mean years of education: 15.1 (1.4)	NR	Married/common-law: 92.9 Single: 7.1

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Milgrom, 2005, 16368032	Individual CBT (46) Group Based counseling (47) Individual counseling (66) TAU (33)	29.7 (5.4)	NR	12 or more years of school 62.7 Higher education 30.5	NR	Living with a partner: 81.4
Milgrom, 2011, 21615968	CBT (Nurse led) (22) CBT (Psychologist led) (23) TAU (Routine GP management) (23)	31.5 (4.4)	NR	High school only 22.1 Degree or Higher 63.2	NR	Married/De Facto 86.8 No partner 10.3
Milgrom, 2015, 25709044	CBT (27) TAU (27)	NR	NR	High school only 20.4 Certificate level 16.7 Diploma level 13.0 University degree 35.2 Postgraduate 14.8	NR	Married/De facto 88.9 Separated/Single 11.1
Milgrom, 2016, 26952645	CBT (21) TAU (22)	31.6 (4.5)	NR	Did not finish school 2.3 High school only 11.6 Certificate level 16.3 Diploma level 20.9 Undergraduate degree 30.2 Postgraduate degree 18.6	NR	Married/Living with partner: 88.4. Single: 11.6

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Mulcahy, 2010, 19697094	IPT (29) TAU (28)	32.2 (3.4)	NR	University education 60.8	Home duties 79.9	Married: 97.9
Ngai, 2015, 26278623	CBT (197) TAU (200)	30.8 (4.1)	Asian ^e 100	Primary or below 0.8 Secondary 42.8 Tertiary/university or above 56.4	Unemployed 19.4 Employed 80.6	Married ^e 100
Nieminen, 2016, 27152849	CBT (28) TAU (28)	34.6 (4.8)	NR	University degree 80.4	Studying 7.1 Employed 67.9 Parental leave 17.9 Unemployed 3.6	Cohabiting/ married: 94.6
O'Hara, 2000, 11074869	IPT (60) TAU (60)	29.6 (4.7)	White or Caucasian: Almost all participants	Years of education, mean (SD) 14.7 (1.9)	Working: 63.3	Married or living with a partner for at least 6 months ^s 100
O'Mahen, 2013, 23319454	CBT (30) TAU (25)	27.01 (5.7) Range 18-43	White or Caucasian: 30.7 Black or African: 58.7 Asian: 7 Hispanic or Latinx: Other: 3.7	Below high school 23.7 High school 29.7 Some college 20.4 College graduate 15.7 Beyond college 10.7	Currently employed for pay 14.7	Partnered 67
O'Mahen, 2013, 23602514	CBT (462) TAU (448)	32.3 (5.2)	NR	None 1.3 Secondary 25.4 Post-16 27.4 First degree of Higher degree 44.1	Leave 65.9 Full or part-time employment 32.8 Student or volunteer 1	Married/cohabiting: 93.6 Divorced/separated/single: 2.7. Not in a relationship now 3.7
O'Mahen, 2014, 24148703	Behavioral Activation (41) TAU (42)	NR	White or Caucasian (British): 92.8 Black or African: 1.2 Asian: 1.2 Hispanic or Latinx NR Other: 2.4 Mixed (white/African/Caribbean) 2.4	None 1.2 Secondary. 18.0 Post-16 years 27.8 Undergraduate degree 30.2 Graduate degree 22.9	Homemaker/maternal leave/disability 80.5 Full- or part-time employment 10.8 Student or volunteer 8.5	Married/cohabiting: 91.6. Not in a relationship now: 8.4

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
O'Mahen, 2022, 35177019	CBT (57) TAU (57)	31.5 (5.09)	White or Caucasian: 63.2 Black: 3.5 Asian: 9.6	Some high school: 9.6 High school diploma/A level: 11.4 Technical college: 11.4 University degree: 30.7 (Post)Graduate degree: 29.8 Other/missing: 7.1	NR	NR
Okatsau, 2023, 37163508	CBT (33) TAU (30)	33.4 (4.50)	NR	High school: 14.3 Junior college/vocational school: 22.7 University/graduate school: 20.0	Full-time work: 60.2 Part-time work: 9.55 Self-employed: 1.5 Unemployed: 28.75	NR
Pearson, 2013, 22884235	CBT (12) TAU (12)	29.0 (5.7)	NR	"A" level or above: 58.3	NR	NR
Prendergast, 2001	CBT (17) TAU (20)	32.2	NR	Tertiary educated 75	NR	Married 92
Pugh, 2016, 26930488	CBT (24) TAU (23)	NR	White or Caucasian: 96 Other: 4	< Grade 12: 6.4 High School Diploma; GED 10.6 College/ Some University 19.1 Undergraduate Degree 46.8 Graduate Degree(s) 17.0	NR	Married/Common-Law 85.1 Engaged 2.1 Dating 2.1 Single 10.6
Segre, 2015, 25486371	Counseling (Listening visit) (41) TAU (25)	26.0 (5.8)	White or Caucasian: 33.9 Black or African: 32.3 Asian: NR Hispanic or Latinx: 40 Other (Multiracial): 8.5	Currently enrolled in school 16.9	Employed 33.5	Married/cohabiting: 47.3

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Shaw, 2014, 25049338	CBT (62) TAU (43)	32.2 (5.9)	White or Caucasian: 61.0 Black or African: NR Asian: NR Hispanic or Latinx: 28.6 Other: NR	less than college degree 36.2	NR	Married/ partner: 96.2. Single/divorced 3.8
Stein, 2018, 29413138	CBT (72) CBT (72)	32.0 (5.5)	White or Caucasian (British): 82.6 Other Ethnicity: 17.4	No qualifications 2.8 School level education 38.2 Certificate or diploma of higher education 11.1 University degree 48.0	NR	Living with father: 87.5
Toth, 2013, 24229549	IPT (99) TAU (29)	25.4 (5.4)	White or Caucasian: 38.3 Black or African: 59.4 Asian: NR Hispanic or Latinx: 21.1 Other: 2.3	High school: 57.8	NR	Married 11.7
Trevillion, 2020, 31634678	CBT (26) TAU (27)	Range < 25 9.4 Range 25-29 15.1 Range 30-39 68.0 Range 40 + 7.6	White or Caucasian: 66.04 Black or African: 26.24 Asian: 1.89 Hispanic or Latinx: NR Other/Mixed: 5.66	None/only school qualifications 15.09 Training/Higher Certificate/Diploma 26.42 Degree/Postgraduate 58.49	Working 83.02 Student 1.89 Unemployed 7.55 Homemaker 5.66 Not working due to illness/other 1.89	Married/ Cohabiting 67.92 Partner not cohabiting 15.09. Single: 16.98

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Upshur, 2016, 27480668	Psychoeducation (89) TAU (60)	27.1 (6.1)	White or Caucasian: 12.8 Black or African: 14.1 Asian: 66.4 Hispanic or Latinx: 8 Other: 8	Less than high school 41.6 High school diploma or GED 28.9 Some college or trade school 23.5 College degree 4.7 Master's degree 1.3	No. employed 34.2	Married 18.1 Living with partner: 13.4 Separated 4.0 Divorced 2.7 Never married 61.7
Van Lieshout, 2021, 34495285	CBT (202) TAU (201)	31.8 (4.4)	White or Caucasian: 72.2 Other races NR	Educational attainment by years, mean (SD) 16.8 (2.4)	NR	Married or common-law relationship: 91.3
Van Lieshout, 2022, 35060398	CBT (57) TAU (62)	30.9 (4.8)	NR	Educational by years, mean (SD) 18.0 (3.4)	NR	Married/common law) 93
Van Lieshout, 2023, 36878891	CBT (229) TAU (232)	31.95 (4.8)	White or Caucasian: 64.5 Black or African: 1.5 Asian: 14.5 Hispanic or Latinx: 4 Other: 17	Years of education 15.6 (2.1)	NR	Married/common law: 93
Vigod, 2021, 33949762	IPT (49) TAU (47)	33 (5.0)	NR	Completed university or college 79.2	NR	Married/cohabiting common law: 98.0
Wiklund, 2010, 20636249	CBT (33) TAU (34)	NR	NR	NR	NR	Married: 95.5
Wirz-Justice, 2011, 21535997	Bright light therapy (24) Placebo light therapy (22)	32.2 (5.1)	Eastern European 14.8	No of school years: 11.6 (3.6)	NR	NR

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Wozney, 2017, 28593360	CBT (32) TAU (30)	29.0 (4.8)	NR	Less than high school 3 High school 25.8 Graduated college 27.4 Undergraduate degree 19.4 Graduate degree 24.2	NR	Married or cohabitating: 80.6. All other 19.5

^aNo numeric data reported, ^b(continuation of current maternity care for 10 weeks, followed by optional ICBT, or to be given ICBT immediately as an add-on to maternity care),

^cFrom eligibility criteria ^dData of massage group was not extracted, ^eFrom eligibility criteria and description of sample in discussion, ^fFrom eligibility criteria, ^gTherapist-Assisted Internet-Delivered Cognitive-Behavior Therapy,

Abbreviation; TAU = Treat as usual, including ((including waitlist/ control/ inactive group), IPT = Interpersonal therapy, NA = Not applicable

Table C-5. Summary of all study arms, KQs, and allocation to evidence map

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
Alhusen, 2021, 32409986	Depression	CBT	TAU	NA	NA	KQ1	No
Amani, 2021, 34758210	Depression	CBT	TAU	NA	NA	KQ1	No
Ammerman, 2013, 23768664	Depression	CBT (Note: Delivered during home visits)	TAU	NA	NA	KQ1	No
Armstrong, 2003, 12956024	Depression	Exercise	TAU	NA	NA	KQ1	No
Bais, 2020, 33115894	Depression	Bright light therapy	Placebo light therapy	NA	NA	KQ1	No
Bittner, 2014, 25062520	Depression	CBT	TAU	NA	NA	KQ1	No
Broberg, 2021, 32862425	Depression	Exercise	TAU	NA	NA	KQ1	No
Burger, 2020, 31806071	Depression	CBT	TAU	NA	NA	KQ1	No
Burns, 2013, 23339584	Depression	CBT	TAU	NA	NA	KQ1	No
Buttner, 2015, 25886805	Depression	Exercise (Note: Yoga)	TAU	NA	NA	KQ1	No
Canfield, 2023, 37853333	Depression/Anxiety	CBT	TAU	NA	NA	KQ1	No
Chabrol, 2002, 12214785	Depression/Anxiety	CBT + Psychoeducation + Supportive therapy + Psychodynamic therapy	TAU	NA	NA	KQ1	Yes
Challacombe, 2017, 28137316	OCD	CBT	TAU	NA	NA	KQ1	No
Challacombe, 2024, 37848088	PTSD, OCD, panic disorder or social anxiety disorder	CBT	CBT	NA	NA	KQ1	Yes
Chiorino, 2020, 31805778	PTSD	EMDR	TAU	NA	NA	KQ1	No
Cho, 2008, 18729297	Depression	CBT	TAU	NA	NA	KQ1	No
Chung, 2012, 22840621	Depression	Acupuncture (Note: Electroacupuncture)	Sham acupuncture	NA	NA	KQ1	No

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
Cluxton-Keller, 2023, 37921846	Depression	Family therapy	Problem-solving therapy	NA	NA	KQ1	No
Cooper, 2003, 12724244	Depression	CBT	TAU	Psychodynamic therapy	Non-directive counseling (Note: listening visits)	KQ1	No
Da Costa, 2009, 19728220	Depression	Exercise	TAU	NA	NA	KQ1	No
Daley, 2008, 18399022	Depression	Exercise	TAU	NA	NA	KQ1	No
Daley, 2015, 25804297	Depression	Exercise	TAU	NA	NA	KQ1	No
Danaher, 2023, 36174746	Depression	CBT	TAU	NA	NA	KQ1	No
Dennis, 2020, 32029010	Depression	IPT	TAU	NA	NA	KQ1	No
Dimidjian, 2017, 28045285	Depression	Behavioral Activation	TAU	NA	NA	KQ1	No
Donmez, 2022, 35339911	Depression	Bright light therapy	Placebo light therapy	NA	NA	KQ1	No
Evans, 2021, 34649534	Depression/Anxiety	IPT (Note: Interpersonal counseling)	CBT	NA	NA	KQ1	Yes
Fancourt, 2018, 29436333	Depression/Anxiety	Singing group	Play Group	TAU	NA	KQ1	Yes
Field, 2009, 19761951	Depression/Anxiety	IPT + Massage	IPT	NA	NA	KQ1	Yes
Field, 2013, 23337557	Depression and Anxiety	Exercise (Note: Yoga+Tai Chi)	TAU	NA	NA	KQ1	No
Field, 2013, 23727060	Depression/Anxiety	IPT	Peer support	NA	NA	KQ1	Yes
Field, 2013, 24138994	Depression/Anxiety	Exercise (Note: Yoga)	Peer support	NA	NA	KQ1	Yes
Forsell, 2017, 28628768	Depression	CBT	TAU	NA	NA	KQ1	No
Forsyth, 2017, 28278021	Depression	Exercise	TAU	NA	NA	KQ1	No
Gamble, 2005, 15725200	PTSD	Non-directive counseling	TAU	NA	NA	KQ1	No

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
Gjerdingen, 2013, 23799688	Depression/Anxiety	Doula support	Peer support	TAU	NA	KQ1	Yes
Green, 2020, 31957479	Depression and Anxiety	CBT	TAU	NA	NA	KQ1	No
Grote, 2009, 19252043	Depression	IPT (Note: Culturally adapted)	TAU (Note: Enhanced usual care)	NA	NA	KQ1	No
Hamilton, 2021, 32997871	Depression/Anxiety	Cognitive Analytic Therapy	TAU	NA	NA	KQ1	Yes
Hankin, 2023, 37074698	Depression	IPT	TAU	NA	NA	KQ1	No
Hayden, 2012, 22526914	Depression	CBT	Non-directive counseling	NA	NA	KQ1	No
Heller, 2020, 32202505	Depression/Anxiety	Problem solving therapy	TAU	NA	NA	KQ1	Yes
Honey, 2002, 12437794	Depression	CBT	TAU	NA	NA	KQ1	No
Horwitz, 2015, 25452159	Depression/Anxiety	CBT (Note: Trauma focused)	Psychoeducation	NA	NA	KQ1	Yes
Huh, 2023, 37498661	Depression	CBT	TAU	NA	NA	KQ1	No
Husain, 2023, 37413896	Depression	CBT (Note: Culturally adapted)	TAU	NA	NA	KQ1	No
Johnson, 2016, 27003141	Depression/Anxiety	IPT	Psychoeducation	NA	NA	KQ1	Yes
Kim, 2019, 30249416	Depression/Anxiety	TMS	Sham TMS	NA	NA	KQ1	Yes
Kozinszky, 2012, 22261988	Depression/Anxiety	CBT + IPT + Psychoeducation	TAU	NA	NA	KQ1	Yes
Lenze, 2017, 28038377	Depression	IPT	TAU (Note: Enhanced usual care)	NA	NA	KQ1	No
Letourneau, 2011, 21385294	Depression/Anxiety	Peer support	TAU	NA	NA	KQ1	Yes
Leung, 2016, 26908335	Depression	CBT	TAU	NA	NA	KQ1	No
Loughnan, 2019, 30266030	Depression and Anxiety	CBT	TAU	NA	NA	KQ1	No

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
Loughnan, 2019, 30877878	Depression and Anxiety	CBT	TAU	NA	NA	KQ1	No
Madigan, 2015, 25703488	PTSD	CBT + Psychoeducation (Note: Trauma focused)	Psychoeducation	NA	NA	KQ1	No
Manber, 2004, 15546651	Depression	Acupuncture	Sham acupuncture	Massage	NA	KQ1	No
Manber, 2010, 20177281	Depression	Acupuncture	Sham acupuncture	Massage	NA	KQ1	No
Mennen, 2021, 33221606	Depression	IPT	TAU	NA	NA	KQ1	No
Merza, 2023, 37649448	Depression	CBT	TAU	NA	NA	KQ1	No
Milgrom, 2005, 16368032	Depression	CBT (Note: Individual format)	CBT (Note: Group format)	Non-directive counseling	TAU	KQ1	No
Milgrom, 2011, 21615968	Depression	CBT (Note: Nurse led)	CBT (Note: Psychologist led)	TAU	NA	KQ1	No
Milgrom, 2015, 25586754	Depression/Anxiety	CBT	Sertraline	CBT	NA	KQ2	Yes
Milgrom, 2015, 25709044	Depression	CBT	TAU	NA	NA	KQ1	No
Milgrom, 2016, 26952645	Depression	CBT	TAU	NA	NA	KQ1	No
Milgrom, 2021, 34889742	Depression/Anxiety	CBT	CBT	TAU	NA	KQ1	Yes
Mitchell, 2012,	Depression/Anxiety	Exercise (Note: Yoga)	Psychoeducation	NA	NA	KQ1	Yes
Mulcahy, 2010, 19697094	Depression	IPT	TAU	NA	NA	KQ1	No
Ngai, 2015, 26278623	Depression	CBT	TAU	NA	NA	KQ1	No
Nieminen, 2016, 27152849	PTSD	CBT (Note: Trauma focused)	TAU	NA	NA	KQ1	No
O'Hara, 2000, 11074869	Depression	IPT	TAU	NA	NA	KQ1	No
O'Hara, 2019, 30447565	Depression/Anxiety	Psychoeducation + Pharmacologic placebo	Psychoeducation + Sertraline	IPT	NA	KQ1	Yes
O'Mahen, 2013, 23319454	Depression	CBT	TAU	NA	NA	KQ1	No
O'Mahen, 2013, 23602514	Depression	Behavioral Activation	TAU	NA	NA	KQ1	No

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
O'Mahen, 2014, 24148703	Depression	Behavioral Activation	TAU	NA	NA	KQ1	No
O'Mahen, 2022, 35177019	Depression/Anxiety	CBT + Psychoeducation + Problem solving therapy + Mindfulness	TAU	NA	NA	KQ1	Yes
O'Mahen, 2022, 35177019	Anxiety	Problem-solving therapy + self-care + psychoeducation	TAU	NA	NA	KQ1	No
Okatsau, 2023, 37163508	Anxiety	CBT	TAU	NA	NA	KQ1	No
Ormsby, 2020, 32658830	Depression/Anxiety	Acupuncture	Progressive muscle relaxation	TAU	NA	KQ1	Yes
Pan, 2023, 37525110	Depression	Mindfulness	TAU	NA	NA	KQ1	Yes
Pearson, 2013, 22884235	Depression	CBT	TAU	NA	NA	KQ1	No
Perkins, 2023, 37270855	Depression	Song writing	TAU	NA	NA	KQ1	Yes
Prendergast, 2001,	Depression	CBT	TAU	NA	NA	KQ1	No
Pugh, 2016, 26930488	Depression	CBT	TAU	NA	NA	KQ1	No
Richter, 2012, 23078196	Depression/Anxiety	CBT+Psychoeducation	TAU	NA	NA	KQ1	Yes
Rojas, 2007, 17993363	Depression/Anxiety	Psychoeducation + Clinical monitoring	TAU	NA	NA	KQ1	Yes
Segre, 2015, 25486371	Depression	Non-directive counseling	TAU	NA	NA	KQ1	No
Sharp, 2010, 20860888	Depression/Anxiety	Non-directive counseling	Antidepressant (Note: SSRI recommended)	NA	NA	KQ2	Yes
Shaw, 2014, 25049338	Depression	CBT	TAU	NA	NA	KQ1	No
Spinelli, 2003, 12611838	Depression/Anxiety	IPT	Psychoeducation	NA	NA	KQ1	Yes
Spinelli, 2013, 23656847	Depression/Anxiety	IPT	Psychoeducation	NA	NA	KQ1	Yes
Stein, 2018, 29413138	Depression	CBT	CBT	NA	NA	KQ1	No
Stuart, 2023, 38074280	Depression	IPT	IPT	NA	NA	KQ1	Yes
Suchan, 2022, 36066958	Depression/Anxiety	CBT+Psychoeducation	TAU	NA	NA	KQ1	Yes

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
Toth, 2013, 24229549	Depression	IPT	TAU (Note: Enhanced usual care)	NA	NA	KQ1	No
Trevillion, 2020, 31634678	Depression	CBT	TAU	NA	NA	KQ1	No
Upshur, 2016, 27480668	PTSD	Psychoeducation	TAU	NA	NA	KQ1	No
Van Horne, 2022, 34866254	Depression/Anxiety	Problem solving therapy	TAU	NA	NA	KQ1	Yes
Van Lieshout, 2021, 34495285	Depression	CBT (Note: 1 day workshop)	TAU	NA	NA	KQ1	No
Van Lieshout, 2022, 35060398	Depression	CBT	TAU	NA	NA	KQ1	No
Van Lieshout, 2023, 36878891	Depression	CBT	TAU	NA	NA	KQ1	No
Vigod, 2019, 31257092	Depression/Anxiety	TMS	Sham TMS	NA	NA	KQ1	Yes
Vigod, 2021, 33949762	Depression	IPT	TAU	NA	NA	KQ1	No
Wiklund, 2010, 20636249	Depression	CBT	TAU	NA	NA	KQ1	No
Wirz-Justice, 2011, 21535997	Depression	Bright light therapy	Light therapy	NA	NA	KQ1	No
Wisner, 2017, 28796940	Depression/Anxiety	Psychoeducation	TAU	NA	NA	KQ1	Yes
Wozney, 2017, 28593360	Depression	CBT	TAU	NA	NA	KQ1	No

Appendix D. Outcomes

Table D-1. Depressive disorders: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
BA vs. TAU	Dimidjian, 2017, 28045285	✓	✓	○	○	✓
	O'Mahen, 2013, 23602514	✓	○	○	○	○
	O'Mahen, 2014, 24148703	✓	○	○	○	○
Bright light vs placebo light therapy	Bais, 2020, 33115894	✓	○	○	○	○
	Donmez, 2022, 35339911	✓	✓	○	○	○
	Wirz-Justice, 2011, 21535997	✓	✓	○	○	○
CBT vs. Counseling vs. TAU	Cooper, 2003, 12724244	✓	✓	✓	○	○
	Hayden, 2012, 22526914	✓	○	○	○	○
	Milgrom, 2005, 16368032	✓	○	○	○	○
CBT vs. TAU	Alhusen, 2021, 32409986	✓	○	✓	○	○
	Amani, 2021, 34758210	✓	○	✓	○	○
	Burns, 2013, 23339584	✓	○	✓	○	○
	Cho, 2008, 18729297	✓	○	○	○	○
	Danaher, 2023, 36174746	✓	○	○	○	○
	Forsell, 2017, 28628768	✓	○	○	○	○
	Honey, 2002, 12437794	✓	○	○	○	○

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
	Huh, 2023, 37498661	✓	○	○	○	○
	Leung, 2016, 26908335	✓	○	○	○	○
	Merza, 2023, 37649448	✓	○	○	○	○
	Milgrom, 2015, 25709044	✓	○	○	○	○
	Milgrom, 2016, 26952645	✓	○	○	○	○
	Ngai, 2015, 26278623	✓	○	○	○	○
	O'Mahen, 2013, 23319454	✓	○	○	○	○
	Pearson, 2013, 22884235	○	✓	○	○	○
	Prendergast, 2001,	✓	○	○	○	○
	Pugh, 2016, 26930488	✓	○	○	○	○
	Trevillion, 2020, 31634678	✓	○	○	○	○
	Van Lieshout, 2022, 35060398	✓	○	✓	○	○
	Van Lieshout, 2023, 36878891	✓	○	✓	○	○
	Wiklund, 2010, 20636249	✓	○	○	○	○
	Wozney, 2017, 28593360	✓	✓	○	○	○
	Van Lieshout, 2021, 34495285	✓	○	✓	○	○
	Husain, 2023, 37413896	✓	○	○	○	○
	Ammerman, 2013, 23768664	✓	✓	✓	○	✓
	Milgrom, 2011, 21615968	✓	○	○	○	○
Counseling vs TAU	Segre, 2015, 25486371	✓	○	○	○	○
Exercise vs. TAU	Armstrong, 2003, 12956024	✓	○	○	○	○
	Broberg, 2021, 32862425	✓	✓	○	○	○

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
	Da Costa, 2009, 19728220	✓	○	○	○	✓
	Daley, 2008, 18399022	✓	○	○	○	○
	Daley, 2015, 25804297	✓	○	○	○	○
	Forsyth, 2017, 28278021	✓	✓	○	○	○
	Buttner, 2015, 25886805	✓	○	○	○	○
IPT vs. TAU	Dennis, 2020, 32029010	✓	✓	○	○	○
	Hankin, 2023, 37074698	✓	✓	○	○	○
	Lenze, 2017, 28038377	✓	○	○	○	✓
	Mennen, 2021, 33221606	✓	○	○	○	○
	Mulcahy, 2010, 19697094	✓	○	✓	○	○
	O'Hara, 2000, 11074869	✓	○	○	○	○
	Toth, 2013, 24229549	✓	○	✓	○	○
	Vigod, 2021, 33949762	✓	✓	○	○	○
	Grote, 2009, 19252043	✓	✓	○	○	✓
Specific vs. Nonspecific Acupuncture	Manber, 2004, 15546651	✓	✓	○	○	○
	Manber, 2010, 20177281	✓	✓	○	○	○
	Chung, 2012, 22840621	✓	✓	○	○	○

Abbreviations: BA = behavioral activation, CBT = cognitive behavioral therapy, TAU = treatment as usual, IPT = interpersonal therapy, counseling = non-directive counseling

✓ = outcome reported, ○ = outcome not reported

Table D-2. Anxiety Disorders: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
Multi vs. TAU	O'Mahen, 2022, 35177019	✓	○	○	○	○
CBT vs. TAU	Okatsau, 2023, 37163508	✓	○	○	○	○

Abbreviations: Multi = multicomponent intervention, CBT = cognitive behavioral therapy, TAU = treatment as usual

✓ = outcome reported, ○ = outcome not reported

Table D-3. Depressive and anxiety disorders: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
Exercise vs. TAU	Field, 2013, 23337557	✓	○	○	○	○
CBT vs. TAU	Green, 2020, 31957479	✓	○	○	○	○
	Loughnan, 2019, 30266030	✓	○	○	○	○
	Loughnan, 2019, 30877878	✓	○	○	○	○

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual

✓ = outcome reported, ○ = outcome not reported

Table D-4. Depressive or anxiety disorders: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
CBT vs. TAU	Bittner, 2014, 25062520	✓	○	○	○	○
	Burger, 2020, 31806071	✓	○	○	○	○

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual

✓ = outcome reported, ○ = outcome not reported

Table D-5. Post-traumatic stress disorder: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
CBT vs. TAU	Madigan, 2015, 25703488	✓	○	○	○	○
	Nieminen, 2016, 27152849	✓	○	○	○	○
	Shaw, 2014, 25049338	✓	○	○	○	○
EMDR vs. TAU	Chiorino, 2020, 31805778	✓	○	✓	○	○
EDU vs. TAU	Upshur, 2016, 27480668	✓	○	○	○	○
Counseling vs. TAU	Gamble, 2005, 15725200	✓	✓	○	○	○

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, EMDR = eye movement desensitization and reprocessing, EDU = psychoeducation, counseling = non-directive counseling

✓ = outcome reported, ○ = outcome not reported

Table D-6. Obsessive-compulsive disorder: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
CBT vs. TAU	Challacombe, 2017, 28137316	✓	○	✓	○	○

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual

✓ = outcome reported, ○ = outcome not reported

Appendix E. Risk of Bias Table

Table E-1. Risk of bias assessment for all included studies

Author, Year, PMID	Randomization	Allocation Concealment	Blinding, Participants	Blinding, Outcome Assessors	Attrition Bias	Reporting Bias	Intention To Treat	Other Bias	Overall RoB
Alhusen, 2021, 32409986	Low	Low	Unclear	Low	Low	Low	Low	Low	Low
Amani, 2021, 34758210	Low	Unclear	High	Low	Low	Low	High	Low	High
Ammerman, 2013, 23768664	Low	Unclear	High	Low	Low	Low	Low	Low	Moderate
Armstrong, 2003, 12956024	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Bais, 2020, 33115894	Low	Low	Low	Low	Low	Low	Low	Low	Low
Bittner, 2014, 25062520	Low	Unclear	High	Low	High	Low	Unclear	Low	Moderate
Broberg, 2021, 32862425	Low	Low	High	High	High	Low	Low	Low	High
Burger, 2020, 31806071	Low	Unclear	High	Low	High	Low	Low	Low	Moderate
Burns, 2013, 23339584	Low	Low	Unclear	Unclear	Low	Low	High	Low	Moderate
Buttner, 2015, 25886805	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Canfield, 2023, 37853333	Low	High	High	Low	Low	Low	Low	Low	Moderate
Challacombe, 2017, 28137316	Low	Low	High	Low	Low	Low	High	Low	High
Chiorino, 2020, 31805778	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Cho, 2008, 18729297	Low	Unclear	Unclear	Unclear	Low	Low	High	Low	Moderate
Chung, 2012, 22840621	Low	Low	Low	Low	High	Unclear	Unclear	Low	Moderate
Cooper, 2003, 12724244	Low	Unclear	High	Low	Low	Low	Low	Low	Unclear
Da Costa, 2009, 19728220	Unclear	Low	High	Low	Low	High	Low	Low	High
Daley, 2008, 18399022	Low	Low	High	Low	Low	Low	High	Low	High

Author, Year, PMID	Randomization	Allocation Concealment	Blinding, Participants	Blinding, Outcome Assessors	Attrition Bias	Reporting Bias	Intention To Treat	Other Bias	Overall RoB
Daley, 2015, 25804297	Low	Low	High	Low	Low	Low	High	Low	High
Danaher, 2023, 36174746	Unclear	Unclear	High	Unclear	Low	Low	Low	Low	Moderate
Dennis, 2020, 32029010	Low	Unclear	High	Low	Low	Low	Low	Low	Moderate
Dimidjian, 2017, 28045285	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Donmez, 2022, 35339911	Low	Low	Low	Low	High	Low	High	Low	High
Field, 2013, 23337557	Unclear	Unclear	High	Unclear	Low	Low	High	Low	High
Forsell, 2017, 28628768	Low	High	Unclear	High	Low	Low	Low	Low	High
Forsyth, 2017, 28278021	Low	Low	High	Low	Unclear	Low	Unclear	Low	Moderate
Gamble, 2005, 15725200	Low	Low	High	Low	Low	Unclear	Low	Low	Moderate
Green, 2020, 31957479	Low	Unclear	High	Low	Low	Unclear	Low	Low	Moderate
Grote, 2009, 19252043	Low	Unclear	Unclear	High	Low	Low	Low	Low	Moderate
Hankin, 2023, 37074698	Low	Low	Unclear	Unclear	Low	Low	Low	Low	Moderate
Hayden, 2012, 22526914	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Honey, 2002, 12437794	Unclear	Unclear	Unclear	Unclear	Unclear	Low	Unclear	Low	Unclear
Huberty, 2020, 32503517	Low	Low	High	Low	Low	Low	High	Low	High
Huh, 2023, 37498661	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Husain, 2023, 37413896	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Lenze, 2017, 28038377	Low	Low	High	High	Low	Low	Low	Low	High
Leung, 2016, 26908335	Unclear	Unclear	High	Unclear	Low	Low	Low	Low	Moderate
Loughnan, 2019, 30266030	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate

Author, Year, PMID	Randomization	Allocation Concealment	Blinding, Participants	Blinding, Outcome Assessors	Attrition Bias	Reporting Bias	Intention To Treat	Other Bias	Overall RoB
Loughnan, 2019, 30877878	Low	Low	High	Unclear	Low	Low	High	Low	High
Madigan, 2015, 25703488	Unclear	Unclear	High	Unclear	Low	Low	Unclear	Low	Unclear
Manber, 2004, 15546651	Unclear	Unclear	Low	Low	Unclear	Unclear	Low	Low	Unclear
Manber, 2010, 20177281	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Mennen, 2021, 33221606	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Merza, 2023, 37649448	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Milgrom, 2005, 16368032	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Milgrom, 2011, 21615968	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Milgrom, 2015, 25709044	Low	Low	High	Low	Low	Low	Low	Low	Low
Milgrom, 2016, 26952645	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Mulcahy, 2010, 19697094	Low	Unclear	Unclear	Low	Unclear	Low	Low	Low	Unclear
Ngai, 2015, 26278623	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Nieminen, 2016, 27152849	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
O'Hara, 2000, 11074869	Low	Low	High	Unclear	High	Unclear	Low	Low	Moderate
O'Hara, 2019, 30447565	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Unclear
O'Mahen, 2013, 23319454	Low	Unclear	Low	Unclear	High	Unclear	Low	Low	Moderate
O'Mahen, 2013, 23602514	Low	Low	Unclear	Unclear	High	Unclear	Low	Low	Moderate
O'Mahen, 2014, 24148703	Low	Low	Unclear	Unclear	Unclear	Low	Low	Low	Unclear
O'Mahen, 2022, 35177019	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Okatsau, 2023, 37163508	Low	Low	High	High	Low	High	High	Low	High

Author, Year, PMID	Randomization	Allocation Concealment	Blinding, Participants	Blinding, Outcome Assessors	Attrition Bias	Reporting Bias	Intention To Treat	Other Bias	Overall RoB
Pearson, 2013, 22884235	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Unclear
Prendergast, 2001	Unclear	Unclear	High	Low	Low	Unclear	Low	Low	Unclear
Pugh, 2016, 26930488	Low	Low	High	Unclear	High	Low	Low	Low	High
Segre, 2015, 25486371	Low	Unclear	High	Low	Low	Low	Low	Low	Moderate
Shaw, 2014, 25049338	Low	High	High	High	Low	Low	Low	Low	High
Spinelli, 2013, 23656847	Low	Unclear	Low	Low	Low	Low	Unclear	Low	Unclear
Stein, 2018, 29413138	Low	Low	Low	Low	Low	Low	High	Low	Moderate
Toth, 2013, 24229549	Low	Unclear	High	High	Low	Low	Low	Low	High
Trevillion, 2020, 31634678	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Upshur, 2016, 27480668	Unclear	Unclear	Unclear	Unclear	Low	Low	High	Low	Moderate
Van Lieshout, 2021, 34495285	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Van Lieshout, 2022, 35060398	Low	Low	High	High	Low	Low	Low	Low	High
Van Lieshout, 2023, 36878891	Low	Low	High	Low	Low	Low	High	Low	High
Vigod, 2021, 33949762	Low	Low	High	Unclear	Low	Low	High	Low	High
Wiklund, 2010, 20636249	Unclear	Unclear	High	Low	Low	Low	Low	Low	Moderate
Wirz-Justice, 2011, 21535997	Low	Low	Low	Low	Low	Low	Low	Low	Low
Wozney, 2017, 28593360	Low	Low	High	Low	Low	Low	Low	Low	Moderate

PMID = PubMed Identifier

From the Cochrane Risk of Bias Tool (each item rated as Low, High, Unsure, or N/A). Ratings are color coded for emphasis only.

- Random: Random sequence generation (selection bias): Selection bias (biased allocation to interventions) due to inadequate generation of a randomized sequence;
- Allocation: Allocation concealment (selection bias): Selection bias (biased allocation to interventions) due to inadequate concealment of allocations prior to assignment;
- Blinding of participants (performance bias): Performance bias due to knowledge of the allocated interventions by participants during the study;
- Blinding of personnel/care providers (performance bias): Performance bias due to knowledge of the allocated interventions by personnel/care providers during the study;
- Blinding of outcome assessor (detection bias): Detection bias due to knowledge of the allocated interventions by outcome assessors;

- Dropout: Incomplete outcome data (attrition bias): Attrition bias due to amount, nature or handling of incomplete outcome data;
- Reporting Bias: Selective outcome reporting (outcome reporting bias):

Appendix F. Results Tables

Table F-1. Acupuncture versus nonspecific acupuncture for depressive disorders: Depressive symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Specific N	Specific Mean (SD)	Non-Specific N	Non-Specific Mean (SD)	MD	SMD (95% CI)
Chung, 2012, 22840621	HAM-D	4	8	11.3 (4.8)	10	9.6 (3.4)	1.7	0.40 (-0.54, 1.33)
	EPDS	4	10	11.1 (5.0)	10	11.4 (4.9)	-0.3	-0.06 (-0.93, 0.82)
	HADS-Depression	4	10	8.8 (3.8)	10	7.3 (1.6)	1.5	0.49 (-0.40, 1.38)
Manber, 2004, 15546651	HAM-D	8	16	9.6 (7.8)	19	12.6 (7.5)	-3.0	-0.38 (-1.06, 0.29)
	BDI	8	16	9.2 (6.1)	19	12.2 (5.4)	-3.0	-0.51 (-1.19, 0.16)
Manber, 2010, 20177281	HAM-D	4	52	Mean diff = -9.38	49	Mean diff = -7.35	-	-

Abbreviations: PMID = PubMed ID, HAM-D = Hamilton depression rating scale, EPDS = Edinburgh Postnatal Depression Scale, HADS = Hospital Anxiety and Depression Scale, BDI = Beck Depression Inventory, SD = standard deviation, MD = mean difference, SMD = Standardized mean difference, CI = confidence interval

Table F-2. Acupuncture versus nonspecific acupuncture for depressive disorders: Side effects

Study, Year, PMID	Measure	Timepoint (Weeks)	Acupuncture n/N Events (%)	Sham Acupuncture n/N Events (%)	RR (95% CI)
Manber, 2010, 20177281	NR	Post-treatment	13/49 (26.5)	4/44 (9.1)	2.92 (1.03, 8.29) a

Abbreviations: PMID = PubMed ID, NR = Not reported, RR = relative risk, CI = confidence interval

^aStatistically significant difference.

Table F-3. Acupuncture versus nonspecific acupuncture for depressive disorders: Illness severity, global and subjective improvement

Study, Year, PMID	Measure	Timepoint (Weeks)	Acupuncture N	Acupuncture Mean (SD)	Sham N	Sham Mean (SD)	MD	SMD (95% CI)
Chung, 2012, 22840621	Severity of illness	4	8	2.5 (1.2)	10	1.8 (0.8)	0.7	0.67 (-0.29, 1.62)
	Global improvement	4	8	2.8 (1.3)	10	2.0 (0.9)	0.8	0.7 (-0.26, 1.66)
	Subjective improvement	4	8	2.5 (0.8)	10	2.3 (0.9)	0.2	0.22 (-0.71, 1.16)

Abbreviations: PMID = PubMed ID, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-4. Behavioral activation versus TAU for depressive disorders: Anxiety symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
O'Mahen, 2014, 24148703	GAD-7	17	31	8.71 (4.61)	28	11.29 (5.49)	-2.58	-0.50 (-1.02 - 0.01)

Abbreviations: PMID = PubMed ID, GAD-7 = general anxiety disorder-7, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-5. Behavioral activation versus TAU for depressive disorders: Remission rate of depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	BA n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Dimidjian, 2017, 28045285	PHQ-9 Score <5	10	36/86 (41.9%)	20/77 (26.0%)	1.61 (1.03- 2.53) ^a

Abbreviations: PMID = PubMed ID, PHQ-9 = Patient Health Questionnaire, BA = behavioral activation, TAU = treatment as usual, RR = relative risk, CI = confidence interval

^aStatistically significant difference.

Table F-6. Behavioral activation versus TAU for depressive disorders: Perceived stress at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Dimidjian, 2017, 28045285	PSS	10	70	19.08 (7.11)	68	22.79 (5.90)	-3.71	-0.56 (-0.90, -0.22) ^a
Dimidjian, 2017, 28045285	PSS	22	64	15.96 (8.51)	66	20.50 (7.10)	-4.54	-0.58 (-0.93, -0.22) ^a

Abbreviations: PMID = PubMed ID, PSS = perceived stress scale, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

^aStatistically significant difference.

Table F-7. Behavioral activation versus TAU for depressive disorders: Behavioral and environmental measures at the end of treatment and follow-up timepoints

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Dimidjian, 2017, 28045285	BADS	10	70	29.28 (10.49)	68	24.40 (8.18)	4.88	0.51 (0.17, 0.85) ^a
Dimidjian, 2017, 28045285	BADS	22	64	33.42 (9.41)	65	28.49 (8.88)	4.93	0.53 (0.19, 0.87) ^a
Dimidjian, 2017, 28045285	EROS	10	70	26.79 (6.45)	68	23.59 (4.71)	3.2	0.56 (0.22, 0.90) ^a
Dimidjian, 2017, 28045285	EROS	22 (3 month follow-up)	64	23.59 (4.71)	65	26.25 (5.62)	-2.66	-0.51 (-0.85, -0.17)

Abbreviations: PMID = PubMed ID, BADS = Behavioral activation for depression scale, EROS = Environmental Reward Observation Scale, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

^aStatistically significant difference.

Table F-8. Behavioral activation versus TAU for depressive disorders: Social impairment at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
O'Mahen, 2014, 24148703	WSAS	17	31	13.13 (6.70)	28	17.18 (7.25)	-4.05	-0.57 (-1.09, -0.05) ^a

Abbreviations: PMID = PubMed ID, WSAS = Work and Social Adjustment Scale, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

^aStatistically significant difference.

Table F-9. Behavioral activation versus TAU for depressive disorders: Perceived availability of social support at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
O'Mahen, 2014, 24148703	SPS	17	31	73.63 (9.83)	28	68.39 (10.49)	5.24	0.50 (-0.01, 1.03)

Abbreviations: PMID = PubMed ID, SPS = Social Provision Scale, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-10. Behavioral activation versus TAU for depressive disorders: Adherence

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Dimidjian, 2017, 28045285	Number of sessions completed (out of 12)	10	87	6.43 (3.64)	-	-	-	-

Abbreviations: PMID = PubMed ID, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-11. Behavioral activation versus TAU for depressive disorders: Satisfaction with treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Dimidjian, 2017, 28045285	CSQ-8	10	87	27.76 (3.83)	-	-	-	-

Abbreviations: PMID = PubMed ID, CSQ-8 = Client Satisfaction Questionnaire, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-12. Bright light therapy versus placebo light therapy for depressive disorders: Remission rates for depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	BLT n/N Events (%)	PLT n/N Events (%)	RR (95% CI)
Wirz-Justice, 2011, 21535997	SIGH-ADS ≤8	5	5/16 (31.1)	2/11 (18.2)	1.72 (0.40, 7.32)
	HAM-D ≤8	5	11/16 (68.8)	4/11 (36.4)	1.89 (0.81, 4.42)
Donmez, 2022, 35339911	HAM-D <8	12	8/12 (66.7)	2/11 (18.2)	3.67 (0.98, 13.67)
	MADRS <10	12	5/12 (41.7)	0/11 (0)	-
	EPDS <12	12	8/12 (66.6)	1/11 (9.1)	7.33 (1.08, 49.58) ^a

Abbreviations: PMID = PubMed ID, BLT = bright light therapy, PLT = placebo light therapy, RR= relative risk, CI = confidence interval, SIGH-ADS = Structured Interview Guide for the Hamilton Depression Rating Scale with Atypical Depression Supplement, HAM-D = Hamilton Depression Rating Scale, MADRS = Montgomery–Åsberg Depression Rating Scale, EPDS = Edinburgh Postnatal Depression Scale

*Statistically significant difference.

Table F-13. Bright light therapy versus placebo light therapy for depressive disorders: Response rate in depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	BLT n/N Events (%)	PLT n/N Events (%)	RR (95% CI)
Donmez, 2022, 35339911	> 50% EPDS	12	5/12 (41.7)	1/11 (9.1)	4.58 (0.63- 33.37)
Donmez, 2022, 35339911	> 50% HDRS	12	7/12 (58.3)	2/11 (18.2)	3.21 (0.84-12.27)
Donmez, 2022, 35339911	> 50% MADRS	12	9/12 (75.0)	2/11 (18.2)	4.13 (1.13-15.07)
Wirz-Justice, 2011, 21535997	> 50% HDRS	5	12/16 (75)	4/11 (36.4)	2.06 (0.90-4.74)
Wirz-Justice, 2011, 21535997	> 50% SIGH-ADS	5	13/16 (81.3)	5/11 (45.4)	1.79 (0.90-3.56)

Abbreviations: PMID = PubMed ID, BLT = bright light therapy, PLT = placebo light therapy, RR = relative risk, CI = confidence interval, SIGH-ADS = Structured Interview Guide for the Hamilton Depression Rating Scale with Atypical Depression Supplement, MADRS = Montgomery–Åsberg Depression Rating Scale, EPDS = Edinburgh Postnatal Depression Scale, HDRS = the Hamilton Depression Rating Scale

Table F-14. Bright light therapy versus placebo light therapy for depressive disorders: Satisfaction with treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BLT N	BLT Mean (SD)	PLT N	PLT Mean (SD)	MD	SMD (95% CI)
Bais, 2020, 33115894	Would you recommend treatment to others? (score 1-10)	6	33	8 (1.3)	34	7 (2.7)	1	0.08 (-0.40-0.56)

Abbreviations: PMID = PubMed ID, BLT = bright light therapy, PLT = placebo light therapy, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-15. Bright light therapy versus placebo light therapy for depressive disorders: Satisfaction with treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BLT n/N Events (%)	PLT n/N Events (%)	Effect size (95% CI)
Bais, 2020, 33115894	Will you continue using light therapy?	6	NR/NR (57.1)	NR/NR (61.5)	-

Abbreviations: PMID = PubMed ID, BLT = bright light therapy, PLT = placebo light therapy, CI = confidence interval, NR = not reported

Table F-16. CBT versus counseling for depressive disorders: Remission rate of depressive symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT n/N Events (%)	Counseling n/N Events (%)	RR (95% CI)
Cooper, 2003, 12724244	SCID	18 wks	24/42 (57)	26/48 (54)	1.05 (0.73, 1.53)

Abbreviations: PMID = PubMed ID, CBT = CBT = Cognitive behavioral therapy, RR= risk ratio, CI = confidence intervals

Table F-17. Counseling versus TAU for depressive disorders: Anxiety symptoms at end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	Counseling N	Counseling Mean (SD)	MD	SMD (95% CI)
Milgrom, 2005, 16368032	BAI	Post-intervention	31	12.26 (9.63)	72	12.90 (13.58)	-0.64	-0.05 (-0.47, 0.37)

Abbreviations: PMID = PubMed ID, BAI: Beck Anxiety Inventory, CBT = Cognitive behavioral therapy, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval

Table F-18. CBT versus counseling for depressive disorders: Parent-infant bonding problems

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT n/N Events (%)	Counseling n/N Events (%)	RR (95% CI)
Cooper, 2003, 12724244	Maternal reports of problems ^a	End of treatment	12/29 (41)	18/25 (72)	0.57 (0.35, 0.95) ^b

Abbreviations: PMID = PubMed ID, CBT = Cognitive behavioral therapy, RR = risk ratio, CI = confidence intervals

^aAdjusted for relationship problems prior to treatment.

^bStatistically significant difference.

Table F-19. CBT versus counseling for depressive disorders: Insecure infant attachment type

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT n/N Events (%)	Counseling n/N Events (%)	RR (95% CI)
Cooper, 2003, 12724244	The Ainsworth Strange Situation secure attachment type	72	22/41 (54)	16/39 (41)	1.31 (0.82, 2.11)

Abbreviations: PMID = PubMed ID, CBT = Cognitive behavioral therapy, RR= risk ratio, CI = confidence intervals

Table F-20. Counseling versus TAU for depressive disorders: Child emotional and behavioral difficulties

Study, Year, PMID	Measure	Timepoint	CBT N	CBT Median (Min, Max)	Counseling N	Counseling Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	BSQ	72	42	5 (0, 13)	46	4 (0,11)	-1	-
Cooper, 2003, 12724244	PBCL scale	5yr	29	4 (0,11)	26	3 (0,14)	-1	-
Cooper, 2003, 12724244	Rutter A2 scale	5yr	31	8 (0,16)	33	9 (3, 33)	1	-
Hayden, 2012, 22526914	BRS	End of treatment	20	56.1 th percentile	14	29.6 th percentile	-	-

Abbreviations: PMID = PubMed ID, Rutter A² scale = Self-report Rutter A² scale, PBCL = Preschool Behavior Checklist, BSQ= Behavioral Screening Questionnaire, BRS = Behavioral Rating Scale, CBT = cognitive behavioral therapy, SMD = standardized mean difference, CI = confidence interval

Table F-21. Counseling versus TAU for depressive disorders: Child cognitive development

Study, Year, PMID	Measure	Timepoint	CBT N	CBT Median (Min, Max)	Counseling N	Counseling Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	Bayley scale	72 weeks	42	114 (64, 150)	46	116 (73, 150)	2	-
	General Cognitive Index of the McCarthy Scales	5yr	35	107 (54, 148)	33	111(69,145)	4	-

Abbreviations: PMID = PubMed ID, Bayley= The Mental Development Index of the Bayley Scales of Infant Development, CBT = Cognitive behavioral therapy, SMD = standardized mean difference, CI = confidence interval

Table F-22. CBT versus TAU for depressive disorders: Perceived stress at the end of treatment

Study, Year, PMID	Measure	Timepoint	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Pugh, 2016, 26930488	DASS- Stress subscale	7-10	19	12.32 (6.26)	21	18.19 (5.79)	5.87	-0.96 (-1.61, -0.30) ^a

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, DASS = Depression Anxiety Stress Scales

^aStatistically significant difference.

Table F-23. CBT versus TAU for depressive disorders: Parenting stress

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Pugh, 2016, 26930488	Parental distress	7-10	19	31.79 (8.93)	21	36.40 (7.49)	4.61	-0.55 (-1.18, 0.08)
	Parent-child dysfunctional interaction	7-10	19	18.58 (5.98)	21	22.20 (6.73)	3.62	-0.56 (-1.19, 0.08)
	Perception of a difficult child	7-10	19	26.26 (6.89)	21	28.80 (8.82)	2.54	-0.31 (-0.94, 0.31)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-24. CBT versus TAU for depressive disorders: Relationship quality at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Cho, 2008, 18729297	Dissatisfaction with communication (MSI-R)	4 (postpartum)	12	14.3 (3.7)	10	18.3 (4.8)	4	-0.91 (-1.79, -0.03) ^a
	Marital dissatisfaction (MSI-R)	4 (postpartum)	12	10.3 (4.6)	10	16.3 (0.5)	6	-1.69 (-2.67, -0.79) ^a

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, MSI-R = Snyder's Marital Satisfaction Inventory-Revised

^aStatistically significant difference.

Table F-25. CBT versus TAU for depressive disorders: Social functioning at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Forsell, 2017, 28628768	WSAS	End of treatment	22	18.9 (9.6)	20	23.1 (6.9)	-6.2	-0.49 (-1.10, 0.13)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, SPS = Social Provisions Scale, WSAS = Work and Social Adjustment Scale

Table F-26. CBT versus TAU for depressive disorders: Adherence (average number of sessions)

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Ammerman, 2013, 23768664	Completed all treatment sessions	15	43	11.2 (5.5)	-	-	-	-

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-27. CBT versus TAU for depressive disorders: Adherence (completed all sessions)

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Ammerman, 2013, 23768664	Completed all treatment sessions	15	25/47 (53%)	-	-

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, RR = relative risk, CI = confidence interval

Table F-28. CBT versus TAU for depressive disorders: Maternal-fetal bond at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Alhusen, 2021, 32409986	MFAS	36 weeks gestation	30	73.6 (6.2)	30	78.2 (6.4)	4.6	-0.72 (-1.24, -0.20) ^a
Burns, 2013, 23339584	PAI	15	16	60.4 (3.0)	10	47.2 (3.3)	-13.2	4.10 (2.71, 5.50) ^a

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, MFAS= Maternal-Fetal Attachment Scale, PAI = Prenatal Attachment Inventory.

^aStatistically significant difference.

Table F-29. CBT versus TAU for depressive disorders: Child cognitive development

Study, Year, PMID	Measure	Timepoint	CBT N	CBT Median (Min, Max)	TAU N	TAU Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	Bayley Scale	72 weeks	24	114 (64, 150)	48	116 (58, 150)	2	-
Cooper, 2003, 12724244	General cognitive index of the McCarthy Scales	5 years	35	107 (54, 148)	39	108 (50, 140)	1	-

Abbreviations: PMID = PubMed ID, Bayley= The Mental Development Index of the Bayley Scales of Infant Development, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval,

Table F-30. CBT versus TAU for depressive disorders: Child emotional and behavioral difficulties scores

Study, Year, PMID	Measure	Timepoint	CBT N	CBT Median (Min, Max)	TAU N	TAU Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	PBCL	5yr	29	4 (0, 11)	33	3 (0, 24)	1	-
Cooper, 2003, 12724244	Rutter A ² Scale	5yr	31	8 (0, 16)	35	11 (1, 28)	3	-

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, PBCL= Pre-school Behavior Checklist, Rutter A² Scale = Self-report Rutter A²scale,

Table F-31. Counseling versus TAU for depressive disorders: Remission rates for depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Cooper, 2003, 12724244	SCID	18	26/48 (54)	20/50 (40)	1.35 (0.88, 2.08)

Abbreviations: PMID = PubMed ID, SCID= Structured Clinical Interview for DSM–III–R, TAU = treatment as usual, RR= relative risk, CI = confidence interval

Table F-32. Counseling versus TAU for depressive disorders: Clinically meaningful difference in depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Segre, 2015, 25486371	HAM-D	8	14/39 (36)	3/21 (14)	2.51 (0.81, 7.77)
	EPDS	8	25/39 (64)	9/21 (43)	1.50 (0.87, 2.58)
	IDAS-GD	8	27/39 (69)	6/21 (29)	2.42 (1.19, 4.92) ^a

Abbreviations: PMID = PubMed ID, HAM-D= Hamilton Rating Scale for Depression, EPDS= the Edinburgh Postnatal Depression Scale, IDAS-GD= The Inventory of Depression and Anxiety Symptoms General Depression scale, TAU = treatment as usual, RR = relative risk, CI = confidence interval

^aStatistically significant difference.

Table F-33. Counseling versus TAU for depressive disorders: Anxiety symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Milgrom, 2005, 16368032	BAI	Post-intervention	72	12.90 (13.58)	18	18.21 (9.58)	-5.31	-0.41 (-0.93, 0.11)

Abbreviations: PMID = PubMed ID, BAI: Beck Anxiety Inventory, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-34. Counseling versus TAU for depressive disorders: Quality-of-life at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Segre, 2015, 25486371	Q-LES-Q	8	39	42.49 (11.57)	21	41.52 (10.48)	0.97	0.09 (-0.45, 0.62)

Abbreviations: PMID = PubMed ID, Q-LES-Q= The Quality of Life, Enjoyment, and Satisfaction Questionnaire, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean differences, CI = confidence interval

Table F-35. Counseling versus TAU for depressive disorders: Social functioning at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Segre, 2015, 25486371	WSAS	8	39	5.56 (10.95)	21	13.67 (10.98)	1.89	-0.7 (-1.3, -0.2)

Abbreviations: PMID = PubMed ID, WSAS= Work and Social Adjustment Scale, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean differences, CI = confidence interval

Table F-36. Counseling versus TAU for depressive disorders: Parent-infant bonding problems

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Cooper, 2003, 12724244	Maternal reports of problems	End of treatment	18/25 (72)	19/23 (83)	0.87 (0.64, 1.19)
	Secure attachment as ascertained by Ainsworth's strange situation	72 weeks	NR/NR (41%)	NR/NR (43%)	-

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, RR = relative risk, CI = confidence interval, NR = Not reported

Table F-37. Counseling versus TAU for depressive disorders: child emotional and behavioral difficulties at 5-year follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Median (Min, Max)	TAU N	TAU Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	BSQ	72	46	4 (0, 11)	48	6 (1, 15)	-2	-
	Rutter A ² scale	5yr	33	11 (1, 28)	35	9 (3, 33)	-2	-
	PBCL scale	5yr	26	3 (0, 24)	33	3 (0, 14)	0	-

Abbreviations: PMID = PubMed ID, BSQ= Behavioral Screening Questionnaire, Rutter A² scale = Self-report Rutter A² scale, PBCL = Preschool Behavior Checklist, TAU = treatment as usual, Min = minimum, Max =maximum, SMD = standardized median differences, CI = confidence interval

Table F-38. Counseling versus TAU for depressive disorders: Child cognitive development at end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Median (Min, Max)	TAU N	TAU Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	Bayley scale	72	46	114 (64, 150)	48	116 (85,150)	-2	-
	General Cognitive Index of the McCarthy Scales	5yr	33	107 (54, 148)	39	108 (50,140)	-1	-

Abbreviations: PMID = PubMed ID, Bayley= The Mental Development Index of the Bayley Scales of Infant Development, TAU = treatment as usual, Min = minimum, Max =maximum, SMD = standardized median differences, CI = confidence interval

Table F-39. Exercise versus TAU for depressive disorders: Remission rate for depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Exercise n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Broberg, 2021, 32862425	EPDS	29-34 gestational weeks	30/133 (23.0)	40/137 (29.0)	0.77 (0.51, 1.16)
Broberg, 2021, 32862425	EPDS	8 weeks postpartum	21/133 (16.0)	49/137 (36)	0.44 (0.28, 0.69)

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, RR = relative risk, CI = confidence interval, EPDS = Edinburgh Postnatal Depression Scale

Table F-40. Exercise versus TAU for depressive disorders: Anxiety scores at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Exercise N	Median (Min, Max)	TAU N	Median (Min, Max)	MD	SMD (95% CI)
Broberg, 2021, 32862425	STAI	8	133	35.4 (NR)	137	36.7	-1.3	-
Broberg, 2021, 32862425	STAI	29-34	133	37.4 (NR)	137	37.3	0.04	-

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, STAI = State-Trait Anxiety Inventory, NR = not reported.

Table F-41. Exercise versus TAU for depressive disorders: Health-related quality-of-life at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	Exercise N	Exercise Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Daley, 2015, 25804297	EQ-5D	26	41	0.78 (0.21)	41	0.72 (0.22)	-0.1	0.28 (-0.16; 0.71)
Daley, 2015, 25804297	EQ-5D	52	40	0.81 (0.21)	38	0.78 (0.23)	-0.03	0.14 (-0.31; 0.58)
Daley, 2015, 25804297	MCS-12	26	42	41.45 (9.99)	42	37.9 (10.3)	3.6	0.35 (-0.08; 0.78)
Daley, 2015, 25804297	MCS-12	52	41	41.6 (12.13)	38	41.02 (12.36)	0.6	0.05 (-0.40; 0.49)
Daley, 2015, 25804297	PCS-12	26	42	51.34 (9.02)	42	51.59 (8.48)	-0.3	-0.3 (-0.46; 0.40)
Daley, 2015, 25804297	PCS-12	52	40	52.16 (9.16)	38	51.6 (8.57)	0.6	0.06 (-0.38; 0.51)

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, EQ-5D = EuroQoL EQ-5D, MCS-12 = Mental Health Component of the Short Form-12 (SF-12), PCS-12 = Physical Health Component of the SF-12, SF-36 = Short-Form 36

Table F-42. Exercise versus TAU for depressive disorders: Perceived availability of social support at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Exercise N	Exercise Mean (SD)	TAU N	TAU Mean (SD)	MD (95%CI)	SMD (95% CI)
Armstrong, 2003, 12956024	SSI	12	10	101.6 (19.3)	10	89.0 (17.4)	12.6	0.66 (-0.25; 1.56)

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, SSI= Social Support Interview

Table F-43. Exercise versus TAU for depressive disorders: Number of minutes spent engaging in aerobic exercise per week

Study, Year, PMID	Measure	Timepoint (Weeks)	Exercise N	Exercise Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Da Costa, 2009, 19728220	Minutes of aerobic exercise per week	12	46	124 (96.3)	42	54.6 (55.8)	69.4	0.86 (0.43, 1.30) ^a

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

^aStatistically significant difference.

Table F-44. IPT versus TAU for depressive disorders: Response rate for depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Grote, 2009, 19252043	50% improvement on EPDS	12	20/25 (80)	8/28 (29)	2.80 (1.51, 5.19) ^a

Abbreviations: PMID = PubMed ID, IPT = Interpersonal therapy, TAU= treatment as usual, RR = relative risk, CI = confidence interval, EPDS = Edinburgh Postnatal Depression Scale

^aStatistically significant difference.

Table F-45. IPT versus TAU for depressive disorders: Remission rate for anxiety symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Dennis, 2011, 21535997	STAT <44	12	62/104 (59.6)	35/100 (35)	1.70 (1.25, 2.32)

Abbreviations: PMID = PubMed ID, IPT = Interpersonal therapy, TAU=treatment as usual, RR = relative risk, CI = confidence interval, STAT= State-Trait Anxiety Inventory

Table F-46. IPT versus TAU for depressive disorders: Remission rate for depression and anxiety symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Dennis, 2011, 21535997	EPDS <12 and STAI < 44	12	86/104 (82.7)	55/100 (55)	1.50 (1.23, 1.83) ^a

Abbreviations: PMID = PubMed ID, IPT = Interpersonal therapy, TAU=treatment as usual, RR = relative risk, CI = confidence interval, EPDS = Edinburgh Postnatal Depression Scale, STAT= State-Trait Anxiety Inventory

^aStatistically significant difference.

Table F-47. IPT versus TAU for depressive disorders: Adherence

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Grote, 2009, 19252043	Completed full course	12	17/25 (68)	2/28 (7)	9.52 (2.44, 37.18) ^a
Lenze, 2017, 28038377	Completed at least 4 sessions	37-39 weeks gestation	15/21 (71.4)	-	-

Abbreviations: PMID = PubMed ID, IPT = Interpersonal therapy, TAU= treatment as usual, RR = relative risk, CI = confidence interval

^aStatistically significant difference.

Table F-48. IPT versus TAU for depressive disorders: Mother-infant relationship at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT N	IPT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Mulcahy, 2010, 19697094	MAI	8	23	97.18 (5.35)	27	92.28 (10.14)	4.9	0.58 (0.01, 1.15) ^a
Toth, 2013, 24229549	DAC	32	97	3.32 (0.37)	28	3.38 (0.39)	0.06	-0.10 (-0.52, 0.32)

Abbreviations: PMID = PubMed ID, IPT = interpersonal therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, DAC = Disorganized Attachment Characteristics, MAI = Maternal Attachment Inventory

^aStatistically significant difference.

Table F-49. IPT versus TAU for depressive disorders: Perceived self-efficacy for parenthood at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT N	IPT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Toth, 2013, 24229549	MEQ	32	97	3.32 (0.37)	28	3.38 (0.39)	-0.06	-0.16 (-0.58, 0.26)

Abbreviations: PMID = PubMed ID, IPT = interpersonal therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, MEQ = Maternal Efficacy Questionnaire

Table F-50. IPT versus TAU for depressive disorders: Social functioning at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT N	IPT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Grote, 2009, 19252043	SAS	12	25	2.37 (0.51)	28	3.00 (0.76)	-0.63	-0.95 (-1.52, -0.38)

Abbreviations: PMID = PubMed ID, IPT = interpersonal therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, SAS = Social and Leisure Domain of the Social Adjustment Scale (SAS scores range from 1 to 5, with higher scores indicating greater impairment.)

Table F-51. IPT versus TAU for depressive disorders: Social support at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT N	IPT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Lenze, 2017, 28038377	SSQR	37-39 week of gestation	21	31.66 (0.95)	21	28.61 (1.79)	3.05	2.09 (1.33, 2.85)
Mulcahy, 2010, 19697094	ISEL	8	23	84.64 (19.89)	27	78.32 (21.32)	6.32	0.30 (-0.26, 0.86)

Abbreviations: PMID = PubMed ID, IPT = interpersonal therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, % CI = confidence interval, SSQR = Social Support Questionnaire Revised Scale (SSQR higher scores indicates greater satisfaction with support available (scores range from 0 to 36)), ISEL = Interpersonal Support Evaluation List.

Table F-52. IPT versus TAU for depressive disorders: Toddler difficult temperament

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT N	IPT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Toth, 2013, 24229549	Anger	32	97	4.4 (0.91)	28	4.45 (0.76)	-0.05	-0.06 (-0.05, 0.47)
	Activity level	32	97	4.54 (0.67)	28	4.6 (0.76)	-0.06	-0.09 (-0.51, 0.33)

Abbreviations: PMID = PubMed ID, IPT = interpersonal therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-53. Multicomponent intervention versus TAU for anxiety disorder: All outcomes

Study, Year, PMID	Measure	Timepoint (Weeks)	MULTI N	MULTI Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
O'Mahnen, 2022, 35177019	EPDS	10	45	10.37 (4.34)	51	10.51 (5.23)	-0.14	-0.03 (-0.43, 0.37)
	GAD-7	10	45	6.40 (3.75)	51	7.58 (4.72)	-1.18	-0.27 (-0.68, 0.13)
	PRAQ	10	45	22.99 (3.90)	51	24.66 (4.20)	-1.67	-0.40 (-0.81, -0.01) ^a
	EQ-5D	10	45	7.20 (1.63)	51	6.90 (1.86)	0.03	0.17 (-0.23, 0.57)

Abbreviations: PMID = PubMed ID, MULTI = multicomponent intervention, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, EPDS = Edinburgh postnatal depression scale, GAD-7 = generalized anxiety disorder 7, PRAQ = pregnancy-related anxiety scale, EQ-5D = EuroQol 5 dimensions.

^aStatistically significant difference.

Table F-54. CBT versus TAU for anxiety disorder: All outcomes

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Okatsau, 2023, 37163508	EPDS	1 month postpartum	32	NR (NR)	29	NR (NR)	-	-
	GAD-7	End of treatment	32	4.66 (3.08)	29	5.31 (4.23)	-0.65	-0.17 (-0.68, 0.33)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, NR = not reported, EPDS = Edinburgh postnatal depression scale, GAD-7 = generalized anxiety disorder 7.

Table F-55. Exercise versus TAU for depressive and anxiety disorders: Depressive symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint	Exercise N	Exercise Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Field, 2013, 23337557	Depression (CES-D)	34	37	23.5 (9.0)	38	23.9 (11.4)	0.4	-0.04 (-0.49, 0.41)

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, CES-D = Center for epidemiology depression scale.

Table F-56. Exercise versus TAU for depressive and anxiety disorders: Anxiety symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint	Exercise N	Exercise Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Field, 2013, 23337557	Anxiety (STAI)	34	37	46.1 (7.9)	38	44.3 (11.4)	-1.8	0.18 (-0.27, 0.63)

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, STAI = State-Trait Anxiety Inventory.

Table F-57. CBT versus TAU for depressive and anxiety disorders: Worry scores at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Green, 2020, 31957479	PSWQ	6	44	53.05 (10.77)	42	65.21 (7.74)	12.16	-1.28 (-1.75, -0.82) ^a

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, PSQW = Penn State Worry Questionnaire

^aStatistically significant difference.

Table F-58. CBT versus TAU for depressive and anxiety disorders: Stress at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Green, 2020, 31957479	PSS	6	44	23.59 (7.69)	42	32.01 (7.23)	8.42	-1.12 (-1.57, -0.66) ^a

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, PSS = Perceived Stress Scale

^aStatistically significant difference.

Table F-59. CBT versus TAU for depressive and/or anxiety disorders: Social support at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Bittner, 2014, 25062520	SOZU	Postpartum	21	4.4 (0.5)	53	4.4 (0.4)	0	0.00 (-0.51, 0.51)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, SOZU = Social Support Scale.

Table F-60. CBT versus TAU for depressive and/or anxiety disorders: Child emotional and behavioral difficulties

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Burger, 2020, 31806071	CBCL	72 weeks postpartum	94	21.8 (11.6)	98	19.8 (12.5)	2	0.17 (-0.11, 0.45)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, CBCL = The Child Behavior Checklist

Table F-61. CBT versus TAU for depressive and/or anxiety disorders: Satisfaction with treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Canfield, 2023, 37853333	CSQ-8	8	15	26 (2.68)	-	-	-	-

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, CSQ-8 = Client Satisfaction Questionnaire.

Table F-62. CBT versus TAU for PTSD: Anxiety symptoms at end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Nieminen, 2016, 27152849	BAI	8	28	10.11 (9.56)	28	11.94 (10.29)	-1.8	-0.18 (-0.71, 0.34)
Shaw, 2014, 25049338	BAI	4-5	57	NR	41	NR	-1.7	NA
Shaw, 2014, 25049338	BAI	26	57	NR	38	NR	-5.3	NA
Madigan, 2015, 25703488	SCARED	26	14	25.73 (13.60)	17	24.00 (16.98)	1.7	0.11 (-0.60; 0.72)
Madigan, 2015, 25703488	SCARED	52	12	23.18 (12.84)	14	16.87 (9.50)	6.3	0.55 (-0.24; 1.33)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, BAI = Beck anxiety inventory, SCARED = Screen for Child Anxiety Related Emotional Disorders

Table F-63. CBT versus TAU for PTSD: Depression symptoms at end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Madigan, 2015, 25703488	Depression	26	14	18.55 (14.42)	17	10.87 (9.42)	7.7	0.62 (-0.10, 1.35)
Madigan, 2015, 25703488	Depression	52	12	18.27 (12.09)	14	10.13 (9.61)	8.1	0.73 (-0.07, 1.53)
Nieminen, 2016, 27152849	BDI	8	28	15.39 (11.92)	28	18.84 (11.66)	-3.5	-0.26 (-0.79, 0.27)
Shaw, 2014, 25049338	BDI	4-5	57	NR	41	NR	-4.1	NA

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, BDI = Beck Depression Inventory

Table F-64. CBT versus TAU for PTSD: Quality-of-life scores at end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Nieminen, 2016, 27152849	Quality of life inventory	8	28	1.42 (2.2)	28	1.56 (1.66)	-0.1	-0.07 (-0.59, 0.45)
Nieminen, 2016, 27152849	Eq-5D	8	28	0.73 (0.25)	28	0.75 (0.20)	-6.6	-0.09 (-0.61, 0.44)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, Eq-5D = EuroQol-5 Dimensions

Table F-65. CBT versus TAU for PTSD: Symptoms of trauma at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Nieminen, 2016, 27152849	Impact of events	8	28	19.22 (14.29)	28	32.76 (16.73)	-13.5	-0.85 (-1.41, -0.31)
Shaw, 2014, 25049338	DTS	4-5	57	NR	41	NR	-7.4	NA
Shaw, 2014, 25049338	DTS	26	57	NR	38	NR	-5.9	NA

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, DST = Davidson Trauma Scale

Table F-66. EMDR versus TAU for PTSD: Symptoms of trauma at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	EMDR N	EMDR Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Chiorino, 2020, 31805778	Impact of events	6	19	16.47 (13.26)	18	25.22 (11.52)	-8.8	-0.69 (-1.35, -0.02)
Chiorino, 2020, 31805778	Impact of events	12	19	9.58 (8.90)	18	17.56 (12.32)	-7.9	-0.73 (-1.39, -0.06)

Abbreviations: PMID = PubMed ID, EMDR = Eye Movement Desensitization and Reprocessing, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-67. EMDR versus TAU for PTSD: Mother-to-infant bonding at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	EMDR N	EMDR Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Chiorino, 2020, 31805778	Mother-to-Infant Bonding Scale	6	19	0.79 (1.08)	18	1.11 (1.23)	-0.3	-0.27 (-0.92, 0.38)
Chiorino, 2020, 31805778	Mother-to-Infant Bonding Scale	12	19	0.42 (0.77)	18	0.78 (1.40)	-0.4	-0.31 (-0.96, 0.34)

Abbreviations: PMID = PubMed ID, EMDR = Eye Movement Desensitization and Reprocessing, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-68. Psychoeducation versus TAU for PTSD: Symptoms of trauma at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	EDU N	EDU Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Upshur, 2016, 27480668	PTSS	8	79	2.68 (0.68)	59	2.69 (0.67)	-0.01	-0.02 (-0.35, 0.32)

Abbreviations: PMID = PubMed ID, EDU = Psychoeducation therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, PTSS = Post Traumatic Stress Scale

Table F-69. Psychoeducation versus TAU for PTSD: Social support at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	EDU N	EDU Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Upshur, 2016, 27480668	Medical Outcomes Study Social Support Scale	8	119	17.76 (5.1)	135	17.27 (5.6)	0.5	0.09 (-0.16, 0.33)

Abbreviations: PMID = PubMed ID, EDU = Psychoeducation therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-70. Counseling versus TAU for PTSD: Remission rate for depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Gamble, 2005, 15725200	EPDS score >12	4-6	16/50 (32.0)	18/53 (34.0)	0.94 (-0.54, 1.64)
Gamble, 2005, 15725200	EPDS score >12	12	4/50 (8.0)	17/53 (32.1)	0.25 (0.09, 0.69) ^a

Abbreviations: PMID = PubMed ID, TAU=treatment as usual, RR = relative risk, CI = confidence interval, EPDS = Edinburgh Postnatal Depression Scale

^aStatistically significant difference.

Table F-71. Counseling versus TAU for PTSD: Remission rate for anxiety symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Gamble, 2005, 15725200	DASS-anxiety (>9)	12	1/50 (2.0)	6/53 (11.3)	0.18 (0.02, 1.42) ^a

Abbreviations: PMID = PubMed ID, TAU=treatment as usual, RR = relative risk, CI = confidence interval, DASS = Depression Anxiety Stress Scale – Anxiety Subscale

^aStatistically significant difference.

Table F-72. Counseling versus TAU for PTSD: Trauma symptoms at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Gamble, 2005, 15725200	MINI-PTSD	4-6	50	4.81 (3.65)	53	5.45 (3.01)	0.7	-0.19 (-0.58, 0.20)
Gamble, 2005, 15725200	MINI-PTSD	12	50	2.54 (2.44)	53	3.83 (3.59)	-1.3	-0.42 (-0.81, -0.02) ^a

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, MINI-PTSD = Mini-International Neuropsychiatric Interview–Post-Traumatic Stress Disorder.

^aStatistically significant difference.

Table F-73. Counseling versus TAU for PTSD: Remission rate for PTSD symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Gamble, 2005, 15725200	DSM-IV-R	4-6	17/50 (34.0)	16/53 (30.0)	1.13 (0.64, 1.98) ^a
Gamble, 2005, 15725200	DSM-IV-R	12	3/50 (6.0)	9/53 (17.0)	0.35 (0.10, 1.23) ^a

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, RR = relative risk, CI = confidence interval, DSM-IV-R = The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised

^aStatistically significant difference.

Table F-74. CBT versus TAU for OCD: All outcomes

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Challacombe, 2017, 28137316	YBOCS	52	17	13.71 (8.95)	16	20.88 (6.34)	-7.7	-0.90 (-1.62, -0.18) ^a
	OCI	52	17	26.18 (23.80)	16	52.23 (30.96)	-26.06	-0.92 (-1.64, -0.20) ^a
	Ainsworth sensitivity (1–9)	52	16	5.41 (1.52)	16	5.25 (1.79)	-0.16	0.09 (-0.60, 0.79)

Abbreviations: PMID = PubMed ID, iCBT = intensive cognitive behavior therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, OCI = Obsessive Compulsive Inventory, YBOCS = Yale–Brown Obsessive–Compulsive Scale.

^aStatistically significant difference.

Appendix A. Methods

A.1 Search Strategies

A.1.1 PubMed Searched 4/20/23

("Breast Feeding"[Mesh] OR "Perinatal Care"[Mesh] OR "Pregnancy"[Mesh] OR "Pregnant Women"[Mesh] OR "pregnancy complications"[Mesh] OR "pregnancy trimesters"[Mesh] OR "Postnatal Care"[Mesh] OR "Perinatal Care"[Mesh] OR "Peripartum Period"[Mesh] OR "Maternal Health Services"[Mesh] OR "fetal growth" OR gestat* OR "gestational age" OR pregnancy OR pregnant OR trimester OR postpartum OR post-partum OR postnatal OR post-natal OR prenatal OR pre-natal OR "pre natal" OR antenatal OR ante-natal OR "ante natal" OR postdelivery OR post-delivery OR "post delivery" OR Peripartum OR Peri-partum OR Peri-natal OR Perinatal OR "fourth trimester" OR "4th trimester" OR matern* OR (traum* AND (birth* OR delivery)) OR abortion OR miscarriage*)

AND

("Anxiety Disorders"[Mesh] OR "Bipolar Disorder"[Mesh] OR "Mood Disorders"[Mesh] OR "Obsessive-Compulsive Disorder"[Mesh] OR "Stress Disorders, Post-Traumatic"[Mesh] OR "Depressive Disorder"[MeSH] OR "Depressive Disorder, Major"[Mesh] OR Depression[Mesh] OR "Mental Health"[Mesh] OR "Mental Disorders"[Mesh] OR "Stress Disorders, Traumatic"[Mesh] OR bipolar OR anxiety OR depress* OR anxiety OR bipolar OR "GAD" OR (mental AND (health OR illness OR disorders)) OR "Obsessive-Compulsive Disorder" OR "OCD" OR "Persistent Depressive Disorder" OR "post-traumatic stress disorder" OR "post-traumatic stress disorders" OR "posttraumatic stress disorder" OR "posttraumatic stress disorders" OR PTSD)

AND

("Psychotherapy"[Mesh] OR "Acupuncture Therapy"[Mesh] OR "Complementary Therapies"[Mesh] OR "Mind-Body Therapies"[Mesh] OR Mindfulness[Mesh] OR Yoga[Mesh] OR "Electroconvulsive Therapy"[Mesh] OR "Sensory Art Therapies"[Mesh] OR "Cognitive behavioral therapy" OR "Cognitive behavioural therapy" OR "Cognitive-behavioral treatment" OR "Cognitive behavioural treatment" OR "CBT" OR "trauma-focused therapy" OR "trauma focused therapy" OR mindfulness OR "cognitive processing therapy" OR cognitive restructuring OR cognitive remediation therapy OR Psychotherapy OR psychodynamic OR ("IPT" NOT insulin) OR "dialectical behavioral therapy" OR "psychodynamic therapy" OR Exposure therapy OR "Narrative Exposure Therapy" OR stress inoculation training OR "Eye movement desensitization and reprocessing therapy" OR "Eye movement desensitisation and reprocessing therapy" OR ECT OR "Acceptance and commitment therapy" OR "Acceptance therapy" OR "Behavioral therapy" OR "Behavioural therapy" OR "Problem-solving therapy" OR "Interpersonal therapy" OR "Imagery rehearsal therapy" OR "Support therapy" OR Psychoeducation OR "Trauma affect regulation" OR "Problem solving therapy" OR electroconvulsive or electroshock OR ((Complementary OR alternative) AND (medic* OR therap*)) OR Relaxation OR Yoga OR Acupuncture OR "Bright light therapy" OR Tai Chi OR "Self-hypnosis and relaxation" OR "Social rhythm therapy" OR "Music therapy" OR "Art therapy" OR "Art therapies" OR "Writing therapy" OR "Writing therapies" OR acupuncture OR supplement OR mind-body OR nondrug OR non-drug OR nonpharmac* OR non-pharmac* OR psychotherap* OR "traditional Chinese" OR "TCM" OR supplement* OR psychoeducation

OR “Culturally Informed” OR “culturally-based intervention” OR “Dual diagnosis therapy” OR “Dual diagnosis treatment” OR “Interpersonal process groups” OR Peer-based OR “peer support”)

AND

("Random Allocation"[Mesh] OR "Clinical Trial" [Publication Type] OR "Double-Blind Method"[Mesh] OR "Single-Blind Method"[Mesh] OR "Placebos"[Mesh] OR random* OR placebo OR ((clinical OR controlled) AND trial*) OR ((singl* OR doubl* OR trebl* OR tripl*) AND (blind* OR mask*)) OR Phase 3 OR Phase III OR RCT OR "Randomized Controlled Trial" [Publication Type] OR systematic[sb])

A.1.2 Cochrane Searched 4/20/23

ID Search Hits

- #1 MeSH descriptor: [Breast Feeding] explode all trees
- #2 MeSH descriptor: [Perinatal Care] explode all trees
- #3 MeSH descriptor: [Pregnancy] explode all trees
- #4 MeSH descriptor: [Pregnant Women] explode all trees
- #5 MeSH descriptor: [Pregnancy Complications] explode all trees
- #6 MeSH descriptor: [Pregnancy Trimesters] explode all trees
- #7 MeSH descriptor: [Postnatal Care] explode all trees
- #8 MeSH descriptor: [Perinatal Care] explode all trees
- #9 MeSH descriptor: [Peripartum Period] explode all trees
- #10 MeSH descriptor: [Maternal Health Services] explode all trees
- #11 “fetal growth” OR gestat* OR “gestational age” OR pregnancy OR pregnant OR trimester OR postpartum OR post-partum OR postnatal OR post-natal OR prenatal OR pre-natal OR “pre natal” OR antenatal OR ante-natal OR “ante natal” OR postdelivery OR post-delivery OR "post delivery" OR Peripartum OR Peri-partum OR Peri-natal OR Perinatal OR "fourth trimester" OR "4th trimester" OR matern* OR (traum* AND (birth* OR delivery)) OR abortion OR miscarriage*
- #12 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11
- #13 MeSH descriptor: [Anxiety Disorders] explode all trees
- #14 MeSH descriptor: [Bipolar Disorder] explode all trees
- #15 MeSH descriptor: [Mood Disorders] explode all trees
- #16 MeSH descriptor: [Obsessive-Compulsive Disorder] explode all trees
- #17 MeSH descriptor: [Stress Disorders, Post-Traumatic] explode all trees
- #18 MeSH descriptor: [Depressive Disorder] explode all trees
- #19 MeSH descriptor: [Depressive Disorder, Major] explode all trees
- #20 MeSH descriptor: [Depression] explode all trees
- #21 MeSH descriptor: [Mental Health] explode all trees
- #22 MeSH descriptor: [Mental Disorders] explode all trees
- #23 MeSH descriptor: [Stress Disorders, Traumatic] explode all trees
- #24 bipolar OR anxiety OR depress* OR anxiety OR bipolar OR “GAD” OR (mental AND (health OR illness OR disorders)) OR "Obsessive-Compulsive Disorder" OR “OCD” OR "Persistent Depressive Disorder" OR "post-traumatic stress disorder" OR "post-traumatic stress disorders" OR "posttraumatic stress disorder" OR "posttraumatic stress disorders" OR PTSD

#25 #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24

#26 MeSH descriptor: [Psychotherapy] explode all trees

#27 MeSH descriptor: [Complementary Therapies] explode all trees

#28 MeSH descriptor: [Mind-Body Therapies] explode all trees

#29 MeSH descriptor: [Mindfulness] explode all trees

#30 MeSH descriptor: [Yoga] explode all trees

#31 Cognitive behavioral therapy OR Cognitive-behavioral therapy OR Cognitive-behavioral treatment OR CBT OR trauma-focused therapy OR trauma focused therapy OR mindfulness OR cognitive processing therapy OR cognitive restructuring OR cognitive remediation therapy OR Psychotherapy OR psychodynamic OR (IPT NOT insulin) OR dialectical behavioral therapy OR psychodynamic therapy OR Exposure therapy OR Narrative Exposure Therapy OR stress inoculation training OR Eye movement desensitization and reprocessing therapy OR ECT OR Acceptance and commitment therapy OR Acceptance therapy OR Behavioral therapy OR Problem-solving therapy OR Interpersonal therapy OR Imagery rehearsal therapy OR Support therapy OR Psychoeducation OR Trauma affect regulation OR Problem solving therapy OR electroconvulsive or electroshock OR ((Complementary OR alternative) AND (medic* OR therap*)) OR Relaxation OR Yoga OR Acupuncture OR Bright light therapy OR Tai Chi OR Self-hypnosis and relaxation OR Social rhythm therapy OR Music therapy OR Art therapy OR Writing therapy OR acupuncture OR supplement OR mind-body OR nondrug OR non-drug OR nonpharmac* OR non-pharmac* OR psychotherap* OR traditional Chinese OR TCM OR supplement* OR psychoeducation OR Culturally Informed OR culturally-based intervention OR Dual diagnosis therapy OR Dual diagnosis treatment OR Interpersonal process groups OR Peer-based OR peer support

#32 MeSH descriptor: [Electroconvulsive Therapy] explode all trees

#33 MeSH descriptor: [Sensory Art Therapies] explode all trees

#34 #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33

#35 #12 AND #25 AND #34

A.1.3 Embase Searched 4/20/23

#59 #32 AND #58

#58 #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47 OR #48 OR #49 OR #50 OR #51 OR #52 OR #53 OR #54 OR #55 OR #56 OR #57

#57 'culturally informed' OR 'culturally-based intervention' OR 'dual diagnosis therapy' OR 'dual diagnosis treatment' OR 'interpersonal process groups'

#56 supplement OR 'mind body' OR nondrug OR 'non drug' OR nonpharmac* OR 'non pharmac*' OR psychotherap* OR 'traditional chinese'

#55 ('music' OR 'art' OR 'writing') AND 'therapy'

#54 'tai chi'

#53 'relaxation training'

#52 (complementary OR alternative) AND (medic* OR therap*)

#51 electroshock

#50 'electric shock'

#49 'psychoeducation'

#48 ('reprocessing' OR 'acceptance' OR 'problem solving' OR 'interpersonal' OR 'imagery rehearsal' OR 'support') AND 'therapy'
 #47 'eye movement desensitization'
 #46 'stress inoculation training'
 #45 'narrative exposure'
 #44 'ipt' NOT insulin
 #43 psychodynamic
 #42 'cognitive' AND ('processing' OR 'behavioural' OR 'remediation') AND 'therapy'
 #41 'mindfulness'
 #40 'trauma focused therapy'
 #39 'cognitive behavioral therapy'
 #38 'electroconvulsive therapy'
 #37 'yoga'
 #36 'mindfulness'
 #35 'alternative medicine'
 #34 'acupuncture'
 #33 'psychotherapy'
 #32 #10 AND #22 AND #31
 #31 #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30
 #30 mental AND (health OR illness OR disorders)
 #29 'mental disease'
 #28 'depression'
 #27 'posttraumatic stress disorder'
 #26 'obsessive compulsive disorder'
 #25 'mood disorder'
 #24 'bipolar disorder'
 #23 'anxiety disorder'
 #22 #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21
 #21 pregnancy OR pregnant OR trimester OR postpartum OR 'post partum' OR postnatal OR 'post natal' OR prenatal OR 'pre natal' OR antenatal OR 'ante natal' OR postdelivery OR 'post delivery' OR peripartum OR 'peri partum' OR 'peri natal' OR perinatal
 #20 'fourth trimester'
 #19 'maternal health service'
 #18 'perinatal period'
 #17 'antenatal care'
 #16 'postnatal care'
 #15 'pregnancy complication'
 #14 'pregnant woman'
 #13 'pregnancy'
 #12 'breast feeding'
 #11 'perinatal care'
 #10
 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9
 #9 'phase 3' OR 'phase iii'
 #8 'phase 3 clinical trial'
 #7 assign* OR allocat* OR volunteer*

#6 singl* AND blind*
 #5 double* AND blind*
 #4 random* OR factorial* OR crossover* OR cross-over* OR placebo*
 #3 'single blind procedure'
 #2 'double blind procedure'
 #1 'randomized controlled trial'/exp OR 'randomized controlled trial'

A.1.4 CINAHL/PsycINFO Searched 4/20/23

(“fetal growth” OR gestat* OR “gestational age” OR pregnancy OR pregnant OR trimester OR postpartum OR post-partum OR postnatal OR post-natal OR prenatal OR pre-natal OR “pre natal” OR antenatal OR ante-natal OR “ante natal” OR postdelivery OR post-delivery OR "post delivery" OR Peripartum OR Peri-partum OR Peri-natal OR Perinatal OR "fourth trimester" OR "4th trimester" OR matern* OR (traum* AND (birth* OR delivery)) OR abortion OR miscarriage*) AND (bipolar OR anxiety OR depress* OR anxiety OR bipolar OR “GAD” OR (mental AND (health OR illness OR disorders)) OR "Obsessive-Compulsive Disorder" OR “OCD” OR "Persistent Depressive Disorder" OR "post-traumatic stress disorder" OR "post-traumatic stress disorders" OR "posttraumatic stress disorder" OR "posttraumatic stress disorders" OR PTSD) AND (Cognitive behavioral therapy OR Cognitive-behavioral therapy OR Cognitive-behavioral treatment OR CBT OR trauma-focused therapy OR trauma focused therapy OR mindfulness OR cognitive processing therapy OR cognitive restructuring OR cognitive remediation therapy OR Psychotherapy OR psychodynamic OR (IPT NOT insulin) OR dialectical behavioral therapy OR psychodynamic therapy OR Exposure therapy OR Narrative Exposure Therapy OR stress inoculation training OR Eye movement desensitization and reprocessing therapy OR ECT OR Acceptance and commitment therapy OR Acceptance therapy OR Behavioral therapy OR Problem-solving therapy OR Interpersonal therapy OR Imagery rehearsal therapy OR Support therapy OR Psychoeducation OR Trauma affect regulation OR Problem solving therapy OR electroconvulsive or electroshock OR ((Complementary OR alternative) AND (medic* OR therap*)) OR Relaxation OR Yoga OR Acupuncture OR Bright light therapy OR Tai Chi OR Self-hypnosis and relaxation OR Social rhythm therapy OR Music therapy OR Art therapy OR Writing therapy OR acupuncture OR supplement OR mind-body OR nondrug OR non-drug OR nonpharmac* OR non-pharmac* OR psychotherap* OR traditional Chinese OR TCM OR supplement* OR psychoeducation OR Culturally Informed OR culturally-based intervention OR Dual diagnosis therapy OR Dual diagnosis treatment OR Interpersonal process groups OR Peer-based OR peer support) AND (meta-analysis OR meta analy* OR metanaly* OR metaanaly* OR met analy* OR (systematic AND (review* OR overview*)) OR ((selection OR inclusion OR exclusion) AND criteria) OR data extraction OR relevant journals OR "Comparative Effectiveness" OR random* OR placebo OR ((clinical OR controlled) AND trial*) OR ((singl* OR doubl* OR trebl* OR tripl*) AND (blind* OR mask*)) OR RCT OR Phase 3 OR Phase III OR "Randomized Controlled Trial" OR systematic review OR meta-analysis)

A.2 Identifying Participants With Mental Health Disorders

If studies have not used a structured diagnostic criteria/diagnostic tool to identify participants with diagnoses of depressive disorders, anxiety disorders, OCD or PTSD (e.g. DSM, SCID, ICD-9, ICD-10, CIS-R, Munich-Composite International Diagnostic Interview, Traumatic Events Scale, The National Institute of Mental Health Diagnostic Interview Schedule), studies must meet the proposed cut-off for at least one of the following validated screening tools to be included.

Cut-offs were identified from previous research. Where possible we used cut-offs recommended by studies that compared the sensitivity, specificity, or positive or negative predictive value of the proposed cut-off with a validated diagnostic tool.

Table A-1 Validated screening tool cut-offs for depressive and anxiety disorders

Disorder	Validated Screening Tool	Proposed Cut-Off	Reference to Support Cut-Off
Depressive disorders	Beck Depression Inventory (BDI)	≥ 12	Milgrom, Jeannette, et al. Screening for postnatal depression in routine primary care: properties of the Edinburgh Postnatal Depression Scale in an Australian sample." Australian & New Zealand Journal of Psychiatry 39.9 (2005): 833-839.
	Center for Epidemiology Depression scale (CES-D)	≥ 16	"The CES-D scale: A self-report depression scale for research in the general population." Applied psychological measurement 1.3 (1977): 385-401.
	Edinburgh Postnatal Depression Scale (EPDS)	≥ 10	Levis, Brooke, et al. "Accuracy of the Edinburgh Postnatal Depression Scale (EPDS) for screening to detect major depression among pregnant and postpartum women: systematic review and meta-analysis of individual participant data." bmj 371 (2020).
	Patient Health Questionnaire (PHQ-9)	≥ 10	Sidebottom, Abbey C., et al. "Validation of the Patient Health Questionnaire (PHQ)-9 for prenatal depression screening." Archives of women's mental health 15 (2012): 367-374.
	Whooley questions/ PHQ-2	Yes	Howard, Louise Michele, et al. "Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy." The British Journal of Psychiatry 212.1 (2018): 50-56.
	Leverton Questionnaire	≥ 12	Csatornai, Sarolta, et al. "Validation of the Leverton Questionnaire as a screening tool for postnatal depression in Hungary." General hospital psychiatry 31.1 (2009): 56-66.
Anxiety disorders	Beck Anxiety Inventory (BAI)	≥ 16	Horwitz, Sarah Mccue, et al. DOES AN INTERVENTION TO REDUCE MATERNAL ANXIETY, DEPRESSION AND TRAUMA ALSO IMPROVE MOTHERS' PERCEPTIONS OF THEIR PRETERM INFANTS' VULNERABILITY?." Infant mental health journal 36.1 (2015): 42-52.
	General Anxiety Disorder (GAD-7)	≥ 7	Zhong, Qiu-Yue, et al. "Diagnostic validity of the generalized anxiety disorder-7 (GAD-7) among pregnant women." PloS one 10.4 (2015): e0125096.
	Hospital Anxiety and Depression (HADS -anxiety subscale)	≥ 11	Meades, Rose, and Susan Ayers. "Anxiety measures validated in perinatal populations: a systematic review." Journal of affective disorders 133.1-2 (2011):
	State Trait Anxiety Inventory (STAI)	≥ 40	Meades, Rose, and Susan Ayers. "Anxiety measures validated in perinatal populations: a systematic review." Journal of affective disorders 133.1-2 (2011): 1-15.
	Hamilton Depression Rating Scale (HAM-D)	≥ 14	Ji, Shuang, et al. "Validity of depression rating scales during pregnancy and the postpartum period: impact of trimester and parity." Journal of psychiatric research 45.2 (2011): 213-219.

A.3 Intervention Coding Taxonomy

Cognitive behavioral (binary: 0=no; 1=yes)

Code YES if:

Intervention described as focusing on changing the participant's thoughts and/or Behaviors (can include information/modules relevant to pregnancy/birth/motherhood)

May be referred to as:

Cognitive behavioral therapy
CBT
Cognitive behavioral counseling
Trauma-focused CBT
Mindfulness-based CBT
CBT with MI engagement

May refer to common CBT techniques/exercises

Code NO if:

- No mention of cognitive behavioral therapy and CBT principles
- Cognitive analytic therapy (CAT)

Interpersonal Psychotherapy (binary: 0=no; 1=yes)

Code YES if:

- Intervention is described as focusing on the participant's interpersonal relationships
- Is described as a derivative/adaptation of IPT or based on IPT principles (e.g. interpersonal counseling)

Code NO if:

- No mention of interpersonal psychotherapy

Psychoeducation (binary: 0=no; 1=yes)

Code YES if

- The intervention is described as psychoeducation, education or general education. Most interventions include some degree of educational content, only code intervention as educational if there is explicit reference to a stand-alone psychoeducation module or intervention.
- Common names may include:
 - Education(al)
 - Psychoeducation(al)
 - Psychosocial education
 - Educational apps

Code No if

- No mention of psychoeducation
- Educational components are described in the context of adapting other manualized interventions (e.g. CBT or IPT) for the perinatal population

Alternative therapies

Yoga/Tai chi (binary: 0=no; 1=yes)

Code YES if:

- Intervention if described as including yoga or tai chi (e.g. moving through poses and breath work)

Code NO if:

- No mention of yoga or tai chi

Acupuncture (binary: 0=no; 1=yes)

Code YES if:

- Intervention is described as including insertion and stimulation of needles. Elements of massage therapy may also be included.

Code No if:

- No mention of acupuncture or needle insertion

Exercise (binary: 0=no; 1=yes)

Code YES if:

- Increasing movement with one specified component of either: duration, intensity, or frequency

Code NO if:

- No description of physical activities

Bright light therapy (binary: 0=no; 1=yes)

Code YES if:

- Intervention is described as including exposure to bright light (typically at a predetermined color temperature) using a bright light box or similar device

Code NO if:

- No mention of bright light therapy

Problem solving therapy (binary: 0=no; 1=yes)

Code YES if:

- Intervention is described as teaching or reinforcing structured skills for identifying and resolving problems

Code NO if:

- No mention of problem solving or problem-solving techniques

Appendix B. Excluded Studies

Table B-1. List of excluded studies with reasons for exclusion

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
1	N/A	Optimizing cognitive and behavioral approaches for perinatal depression: A systematic review and meta-regression analysis	Global Mental Health	Waqas A.; Zafar S. W.; Akhtar P.; Naveed S.; Rahman A.	Design: Systematic review
2	31698704	Music interventions for anxiety in pregnant women: A systematic review and meta-analysis of randomized controlled trials	Journal of Clinical Medicine	Lin C. J.; Chang Y. C.; Chang Y. H.; Hsiao Y. H.; Lin H. H.; Liu S. J.; Chao C. A.; Wang H.; Yeh T. L.	Design: Systematic review
3	N/A	Long term effectiveness of cognitive behavior therapy for treatment of postpartum depression: A systematic review and meta-analysis	Journal of Pakistan Medical Students	Perveen T.; Mahmood S.; Gosadi I.; Mehraj J.; Sheikh S. S.	Design: Systematic review
4	34262468	Exercise During Pregnancy and Prenatal Depression: A Systematic Review and Meta-Analysis	Frontiers in Physiology	Sanchez-Polan M.; Franco E.; Silva-Jose C.; Gil-Ares J.; Perez-Tejero J.; Barakat R.; Refoyo I.	Design: Systematic review
5	N/A	Group treatment of postpartum depression: A systematic review	Archives of Women's Mental Health	Goodman J. H.	Design: Systematic review
6	N/A	Aromatherapy for Postpartum Depression: A Systematic Review and Meta-Analysis	Journal of Family and Reproductive Health	Shamsunisha Y.; Arunesh A.; Pandiaraja M.; Venugopal V.; Poonguzhali S.; Kuppusamy M.	Design: Systematic review
7	30613846	Non-pharmacological interventions to reduce the symptoms of mild to moderate anxiety in pregnant women. A systematic review and narrative synthesis of women's views on the acceptability of and satisfaction with interventions	Archives of Women's Mental Health	Evans K.; Spiby H.; Morrell J. C.	Design: Systematic review
8	34147932	Efficacy of non-invasive brain stimulation in decreasing depression symptoms during the peripartum period: A systematic review	Journal of Reproductive and Infant Psychology	Pacheco F.; Guiomar R.; Brunoni A.; Buhagiar R.; Evagorou O.; Roca-Lecumberri A.; Poleszczyk A.; Lambregtse-Van Den Berg M.; Caparros-Gonzalez R.; Fonseca A.; Osrio A.; Soliman M.; Ganho-Ávila A.	Design: Systematic review
9	34942447	Effect of peer support intervention on perinatal depression: A meta-analysis	General Hospital Psychiatry	Fang Q.; Lin L.; Chen Q.; Yuan Y.; Wang S.; Zhang Y.; Liu T.; Cheng H.; Tian L.	Design: Systematic review
10	36991389	Effectiveness of cognitive behavioural therapy-based interventions for maternal perinatal depression: a systematic review and meta-analysis	BMC Psychiatry	Pettman D.; O'Mahen H.; Blomberg O.; Svanberg A. S.; von Essen L.; Woodford J.	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
11	25960678	Interventions for postnatal depression assessing the mother-infant relationship and child developmental outcomes: A systematic review	International Journal of Women's Health	Tsivos Z. L.; Calam R.; Sanders M. R.; Wittkowski A.	Design: Systematic review
12	32765754	Role of midwife-supported psychotherapy on antenatal depression, anxiety and maternal health: A meta-analysis and literature review	Experimental and Therapeutic Medicine	Han Q.; Guo M.; Ren F.; Duan D.; Xu X.	Design: Systematic review
13	15209173	Intervening to reduce depression after birth: a systematic review of the randomized trials	Int J Technol Assess Health Care	Lumley J.; Austin M. P.; Mitchell C.	Design: Systematic review
14	15367053	Treatment of postpartum depression, part 1: a critical review of biological interventions	J Clin Psychiatry	Dennis C. L.; Stewart D. E.	Design: Systematic review
15	15367054	Treatment of postpartum depression, part 2: a critical review of nonbiological interventions	J Clin Psychiatry	Dennis C. L.	Design: Systematic review
16	17636841	Psychosocial and psychological interventions for treating antenatal depression	Cochrane Database Syst Rev	Dennis C. L.; Ross L. E.; Grigoriadis S.	Design: Systematic review
17	17943888	Psychosocial and psychological interventions for treating postpartum depression	Cochrane Database Syst Rev	Dennis C. L.; Hodnett E.	Design: Systematic review
18	17978316	Effects of treating postnatal depression on mother-infant interaction and child development: systematic review	Br J Psychiatry	Poobalan A. S.; Aucott L. S.; Ross L.; Smith W. C.; Helms P. J.; Williams J. H.	Design: Systematic review
19	18843730	Interventions (other than pharmacological, psychosocial or psychological) for treating antenatal depression	Cochrane Database Syst Rev	Dennis C. L.; Allen K.	Design: Systematic review
20	19126829	The effectiveness of exercise in the management of post-natal depression: systematic review and meta-analysis	Fam Pract	Daley A.; Jolly K.; MacArthur C.	Design: Systematic review
21	19137448	A systematic review of home-based interventions to prevent and treat postpartum depression	Arch Womens Ment Health	Leis J. A.; Mendelson T.; Tandon S. D.; Perry D. F.	Design: Systematic review
22	19445768	Postnatal depression	BMJ Clin Evid	Craig M.; Howard L.	Design: Systematic review
23	20653342	Management of post traumatic stress disorder after childbirth: a review	J Psychosom Obstet Gynaecol	Lapp L. K.; Agbokou C.; Peretti C. S.; Ferreri F.	Design: Systematic review
24	20863477	Group cognitive behavioural therapy for postnatal depression: a systematic review of clinical effectiveness, cost-effectiveness and value of information analyses	Health Technol Assess	Stevenson M. D.; Scope A.; Sutcliffe P. A.; Booth A.; Slade P.; Parry G.; Saxon D.; Kalthenthaler E.	Design: Systematic review
25	21545782	A meta-analysis of treatments for perinatal depression	Clin Psychol Rev	Sockol L. E.; Epperson C. N.; Barber J. P.	Design: Systematic review
26	21720793	Group treatment for postpartum depression: a systematic review	Arch Womens Ment Health	Goodman J. H.; Santangelo G.	Design: Systematic review
27	21735413	Mind-body interventions during pregnancy for preventing or treating women's anxiety	Cochrane Database Syst Rev	Marc I.; Toureche N.; Ernst E.; Hodnett E. D.; Blanchet C.; Dodin S.; Njoya M. M.	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
28	23904069	Interventions (other than pharmacological, psychosocial or psychological) for treating antenatal depression	Cochrane Database Syst Rev	Dennis C. L.; Dowswell T.	Design: Systematic review
29	24240636	Efficacy of systemically oriented psychotherapies in the treatment of perinatal depression: a meta-analysis	Arch Womens Ment Health	Claridge A. M.	Design: Systematic review
30	24283266	Is group cognitive behaviour therapy for postnatal depression evidence-based practice? A systematic review	BMC Psychiatry	Scope A.; Leaviss J.; Kaltenthaler E.; Parry G.; Sutcliffe P.; Bradburn M.; Cantrell A.	Design: Systematic review
31	24957781	Interpersonal psychotherapy for postpartum depression: a systematic review	Arch Womens Ment Health	Miniati M.; Callari A.; Calugi S.; Rucci P.; Savino M.; Mauri M.; Dell'Osso L.	Design: Systematic review
32	25238209	A systematic review of perinatal depression interventions for adolescent mothers	J Adolesc	Lieberman K.; Le H. N.; Perry D. F.	Design: Systematic review
33	25522839	The effects of psychological treatment of maternal depression on children and parental functioning: a meta-analysis	Eur Child Adolesc Psychiatry	Cuijpers P.; Weitz E.; Karyotaki E.; Garber J.; Andersson G.	Design: Systematic review
34	25652267	Yoga for prenatal depression: a systematic review and meta-analysis	BMC Psychiatry	Gong H.; Ni C.; Shen X.; Wu T.; Jiang C.	Design: Systematic review
35	25743368	A systematic review of the efficacy of cognitive behavioral therapy for treating and preventing perinatal depression	J Affect Disord	Sockol L. E.	Design: Systematic review
36	26346905	Mindfulness and perinatal mental health: A systematic review	Women Birth	Hall H. G.; Beattie J.; Lau R.; East C.; Anne Biro M.	Design: Systematic review
37	27621164	Effectiveness of Psychological Interventions for Postnatal Depression in Primary Care: A Meta-Analysis	Ann Fam Med	Stephens S.; Ford E.; Paudyal P.; Smith H.	Design: Systematic review
38	28358808	Interventions to treat mental disorders during pregnancy: A systematic review and multiple treatment meta-analysis	PLoS One	van Ravesteyn L. M.; Lambregtse-van den Berg M. P.; Hoogendijk W. J.; Kamperman A. M.	Design: Systematic review
39	28702773	Can exercise or physical activity help improve postnatal depression and weight loss? A systematic review	Arch Womens Ment Health	Saligheh M.; Hackett D.; Boyce P.; Cobley S.	Design: Systematic review
40	28757900	The Effectiveness of Mindfulness-Based Interventions on Maternal Perinatal Mental Health Outcomes: a Systematic Review	Mindfulness (N Y)	Shi Z.; MacBeth A.	Design: Systematic review
41	28962068	The effect of perinatal depression treatment for mothers on parenting and child development: A systematic review	Depress Anxiety	Letourneau N. L.; Dennis C. L.; Cosic N.; Linder J.	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
42	29201244	Mindfulness-Based Interventions During Pregnancy: a Systematic Review and Meta-analysis	Mindfulness (N Y)	Dhillon A.; Sparkes E.; Duarte R. V.	Design: Systematic review
43	29368048	A systematic review of psychological treatments for clinical anxiety during the perinatal period	Arch Womens Ment Health	Loughnan S. A.; Wallace M.; Joubert A. E.; Haskelberg H.; Andrews G.; Newby J. M.	Design: Systematic review
44	29616334	Effectiveness of self-help psychological interventions for treating and preventing postpartum depression: a meta-analysis	Arch Womens Ment Health	Lin P. Z.; Xue J. M.; Yang B.; Li M.; Cao F. L.	Design: Systematic review
45	29882074	The effectiveness of exercise-based interventions for preventing or treating postpartum depression: a systematic review and meta-analysis	Arch Womens Ment Health	Carter T.; Bastounis A.; Guo B.; Jane Morrell C.	Design: Systematic review
46	29902211	Clinical effectiveness of family therapeutic interventions in the prevention and treatment of perinatal depression: A systematic review and meta-analysis	PLoS One	Cluxton-Keller F.; Bruce M. L.	Design: Systematic review
47	29907576	Effectiveness of acupuncture in postpartum depression: a systematic review and meta-analysis	Acupunct Med	Li S.; Zhong W.; Peng W.; Jiang G.	Design: Systematic review
48	29935979	Treatment of depression, anxiety, and trauma-related disorders during the perinatal period: A systematic review	Clin Psychol Rev	Nilini Y. I.; Mehralizade A.; Mayer L.; Milanovic S.	Design: Systematic review
49	30068424	Opening windows of opportunities: Evidence for interventions to prevent or treat depression in pregnant women being associated with changes in offspring's developmental trajectories of psychopathology risk	Dev Psychopathol	Goodman S. H.; Cullum K. A.; Dimidjian S.; River L. M.; Kim C. Y.	Design: Systematic review
50	30313002	Antidepressant Treatment of Depression During Pregnancy and the Postpartum Period	Evid Rep Technol Assess (Full Rep)	McDonagh M.; Matthews A.; Phillipi C.; Romm J.; Peterson K.; Thakurta S.; Guise J. M.	Design: Systematic review
51	30321198	Is cognitive behavioral therapy a better choice for women with postnatal depression? A systematic review and meta-analysis	PLoS One	Huang L.; Zhao Y.; Qiang C.; Fan B.	Design: Systematic review
52	30343660	The effectiveness of telemedicine interventions to address maternal depression: A systematic review and meta-analysis	J Telemed Telecare	Nair U.; Armfield N. R.; Chatfield M. D.; Edirippulige S.	Design: Systematic review
53	30388545	The efficacy of cognitive behavior therapy for the treatment of perinatal anxiety symptoms: A preliminary meta-analysis	J Anxiety Disord	Maguire P. N.; Clark G. I.; Wootton B. M.	Design: Systematic review
54	30396632	A systematic review of acupuncture and Chinese herbal medicine for postpartum depression	Complement Ther Clin Pract	Yang L.; Di Y. M.; Shergis J. L.; Li Y.; Zhang A. L.; Lu C.; Guo X.; Xue C. C.	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
55	30423471	The effect of complementary medicines and therapies on maternal anxiety and depression in pregnancy: A systematic review and meta-analysis	J Affect Disord	Smith C. A.; Shewamene Z.; Galbally M.; Schmied V.; Dahlen H.	Design: Systematic review
56	30428883	Offspring outcomes after prenatal interventions for common mental disorders: a meta-analysis	BMC Med	Brouwer M. E.; Williams A. D.; van Grinsven S. E.; Cuijpers P.; Lambregtse-van den Berg M. P.; Burger H.; Bockting C. L. H.	Design: Systematic review
57	30515108	Effectiveness of Trauma-Focused Psychological Therapies for Treating Post-traumatic Stress Disorder Symptoms in Women Following Childbirth: A Systematic Review and Meta-Analysis	Front Psychiatry	Furuta M.; Horsch A.; Ng E. S. W.; Bick D.; Spain D.; Sin J.	Design: Systematic review
58	30688418	Effectiveness of eHealth Interventions to Reduce Perinatal Anxiety: A Systematic Review and Meta-Analysis	J Clin Psychiatry	Bayrampour H.; Trieu J.; Tharmaratnam T.	Design: Systematic review
59	30712750	A meta-analysis of the effectiveness of yoga-based interventions for maternal depression during pregnancy	Complement Ther Clin Pract	Ng Q. X.; Venkatanarayanan N.; Loke W.; Yeo W. S.; Lim D. Y.; Chan H. W.; Sim W. S.	Design: Systematic review
60	31057080	The efficiency of online cognitive-behavioral therapy for postpartum depressive symptomatology: a systematic review and meta-analysis	Women Health	Roman M.; Constantin T.; Bostan C. M.	Design: Systematic review
61	31101993	Internet-delivered psychological interventions for clinical anxiety and depression in perinatal women: a systematic review and meta-analysis	Arch Womens Ment Health	Loughnan S. A.; Joubert A. E.; Grierson A.; Andrews G.; Newby J. M.	Design: Systematic review
62	31129438	A systematic review of the safety and effectiveness of repetitive transcranial magnetic stimulation in the treatment of peripartum depression	J Psychiatr Res	Cole J.; Bright K.; Gagnon L.; McGirr A.	Design: Systematic review
63	31164035	Treatment of posttraumatic stress disorder following childbirth	J Psychosom Obstet Gynaecol	de Bruijn L.; Stramrood C. A.; Lambregtse-van den Berg M. P.; Rius Ottenheim N.	Design: Systematic review
64	31196691	Efficacy of rTMS in decreasing postnatal depression symptoms: A systematic review	Psychiatry Res	Ganho-Avila A.; Poleszczyk A.; Mohamed M. M. A.; Osorio A.	Design: Systematic review
65	31259837	Traditional Chinese acupuncture and postpartum depression: A systematic review and meta-analysis	J Chin Med Assoc	Tong P.; Dong L. P.; Yang Y.; Shi Y. H.; Sun T.; Bo P.	Design: Systematic review
66	31541788	The effectiveness of music therapy for postpartum depression: A systematic review and meta-analysis	Complement Ther Clin Pract	Yang W. J.; Bai Y. M.; Qin L.; Xu X. L.; Bao K. F.; Xiao J. L.; Ding G. W.	Design: Systematic review

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67	31550613	The short- and long-term effectiveness of mother-infant psychotherapy on postpartum depression: A systematic review and meta-analysis	J Affect Disord	Huang R.; Yang D.; Lei B.; Yan C.; Tian Y.; Huang X.; Lei J.	Design: Systematic review
68	31619096	The effect of cognitive-behavioral therapy on psychological distress in the mothers of preterm infants: a systematic review and meta-analysis	J Psychosom Obstet Gynaecol	Seiiedi-Biarag L.; Mirghafourvand M.; Ghanbari-Homayi S.	Design: Systematic review
69	31928569	Effects of parenting interventions for mothers with depressive symptoms and an infant: systematic review and meta-analysis	BJPsych Open	Rayce S. B.; Rasmussen I. S.; Vaever M. S.; Pontoppidan M.	Design: Systematic review
70	32553366	A systematic review of non-invasive neurostimulation for the treatment of depression during pregnancy'	J Affect Disord	Konstantinou G. N.; Vigod S. N.; Mehta S.; Daskalakis Z. J.; Blumberger D. M.	Design: Systematic review
71	32553392	The efficacy of cognitive behavioral therapy for the treatment of antenatal depression: A systematic review	J Affect Disord	Shortis E.; Warrington D.; Whittaker P.	Design: Systematic review
72	32563204	Effectiveness of cognitive behavioural therapy for perinatal depression: A systematic review and meta-analysis	J Clin Nurs	Li Z.; Liu Y.; Wang J.; Liu J.; Zhang C.	Design: Systematic review
73	32629701	Role of psychotherapy on antenatal depression, anxiety, and maternal quality of life: A meta-analysis	Medicine (Baltimore)	Li C.; Sun X.; Li Q.; Sun Q.; Wu B.; Duan D.	Design: Systematic review
74	32738663	Effectiveness of peer support intervention on perinatal depression: A systematic review and meta-analysis	J Affect Disord	Huang R.; Yan C.; Tian Y.; Lei B.; Yang D.; Liu D.; Lei J.	Design: Systematic review
75	33358645	The contribution of group prenatal care to maternal psychological health outcomes: A systematic review	Women Birth	Buultjens M.; Farouque A.; Karimi L.; Whitby L.; Milgrom J.; Erbas B.	Design: Systematic review
76	33563220	Repetitive transcranial magnetic stimulation treatment for peripartum depression: systematic review & meta-analysis	BMC Pregnancy Childbirth	Lee H. J.; Kim S. M.; Kwon J. Y.	Design: Systematic review
77	33637070	Psychological interventions for maternal depression among women of African and Caribbean origin: a systematic review	BMC Womens Health	Jidong D. E.; Husain N.; Roche A.; Lourie G.; Ike T. J.; Murshed M.; Park M. S.; Karick H.; Dagona Z. K.; Pwajok J. Y.; Gumber A.; Francis C.; Nyam P. P.; Mwankon S. B.	Design: Systematic review
78	34062397	Effectiveness of psychological interventions in the treatment of perinatal depression: A systematic review of systematic reviews and meta-analyses	J Affect Disord	Branquinho M.; Rodriguez-Munoz M. F.; Maia B. R.; Marques M.; Matos M.; Osma J.; Moreno-Peral P.; Conejo-Ceron S.; Fonseca A.; Voursora E.	Design: Systematic review

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79	34464836	Non-pharmacological interventions to reduce anxiety in pregnancy, labour and postpartum: A systematic review	Midwifery	Dominguez-Solis E.; Lima-Serrano M.; Lima-Rodriguez J. S.	Design: Systematic review
80	34714882	Mobile interventions targeting common mental disorders among pregnant and postpartum women: An equity-focused systematic review	PLoS One	Saad A.; Magwood O.; Aubry T.; Alkhateeb Q.; Hashmi S. S.; Hakim J.; Ford L.; Kassam A.; Tugwell P.; Pottie K.	Design: Systematic review
81	34749125	The effectiveness of psychological interventions for pregnant women with anxiety in the antenatal period: A systematic review	Midwifery	Callanan F.; Tuohy T.; Bright A. M.; Grealish A.	Design: Systematic review
82	34849370	A Systematic Review and Meta-analysis of the Effects of Music Therapy on Postpartum Anxiety and Pain Levels	J Caring Sci	Hakimi S.; Hajizadeh K.; Hasanzade R.; Ranjbar M.	Design: Systematic review
83	34943246	Effects of Exercise during Pregnancy on Postpartum Depression: A Systematic Review of Meta-Analyses	Biology (Basel)	Marconcin P.; Peralta M.; Gouveia E R.; Ferrari G.; Carraca E.; Ihle A.; Marques A.	Design: Systematic review
84	35123346	Effectiveness of cognitive behavioral therapy for perinatal maternal depression, anxiety and stress: A systematic review and meta-analysis of randomized controlled trials	Clin Psychol Rev	Li X.; Laplante D. P.; Paquin V.; Lafortune S.; Elgbeili G.; King S.	Design: Systematic review
85	35166688	Remotely Delivered Interventions to Support Women With Symptoms of Anxiety in Pregnancy: Mixed Methods Systematic Review and Meta-analysis	J Med Internet Res	Evans K.; Rennick-Egglestone S.; Cox S.; Kuipers Y.; Spiby H.	Design: Systematic review
86	35188471	eHealth Interventions for Treatment and Prevention of Depression, Anxiety, and Insomnia During Pregnancy: Systematic Review and Meta-analysis	JMIR Ment Health	Silang K. A.; Sohal P. R.; Bright K. S.; Leason J.; Roos L.; Lebel C.; Giesbrecht G. F.; Tomfohr-Madsen L. M.	Design: Systematic review
87	35257692	Effect of mindfulness-based interventions on mental health of perinatal women with or without current mental health issues: A systematic review and meta-analysis of randomized controlled trials	J Affect Disord	Yan H.; Wu Y.; Li H.	Design: Systematic review
88	35286442	Exercise and yoga during pregnancy and their impact on depression: a systematic literature review	Arch Womens Ment Health	Jarbou N. S.; Newell K. A.	Design: Systematic review
89	35514260	Resilience-enhancing interventions for antepartum depressive symptoms: systematic review	BJPsych Open	Walker A. L.; Witteveen A. B.; Otten R. H. J.; Verhoeven C. J.; Henrichs J.; de Jonge A.	Design: Systematic review
90	35564762	Efficacy of Prenatal Yoga in the Treatment of Depression and Anxiety during Pregnancy: A Systematic Review and Meta-Analysis	Int J Environ Res Public Health	Lin I. H.; Huang C. Y.; Chou S. H.; Shih C. L.	Design: Systematic review

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91	35772128	Yoga's Therapeutic Effect on Perinatal Depression: A Systematic Review and Meta-Analysis	Psychiatr Danub	Wang G.; Liang C.; Sun G.	Design: Systematic review
92	35887812	Efficacy and Safety of Transcranial Electric Stimulation during the Perinatal Period: A Systematic Literature Review and Three Case Reports	J Clin Med	Laurin A.; Nard N.; Dalmont M.; Bulteau S.; Benard C.; Bonnot O.; Winer N.; Dupont F.; Apter G.; Terranova-Commessie F.; Guillin O.; El-Hage W.; Sauvaget A.; Rotharmel M.	Design: Systematic review
93	36186359	Effect of mindfulness meditation on depression during pregnancy: A meta-analysis	Front Psychol	Li Y.; Chen J.; Chen B.; Wang T.; Wu Z.; Huang X.; Li S.	Design: Systematic review
94	36423436	Internet-delivered mindfulness-based interventions for mental health outcomes among perinatal women: A systematic review	Asian J Psychiatr	Mao F.; Sun Y.; Li Y.; Cui N.; Cao F.	Design: Systematic review
95	36504355	The effectiveness of psychological interventions for anxiety in the perinatal period: A systematic review and meta-analysis	Psychol Psychother	Clinkscales N.; Golds L.; Berlouis K.; MacBeth A.	Design: Systematic review
96	36707743	Systematic Review of Online Interventions to Reduce Perinatal Mood and Anxiety Disorders in Underserved Populations	J Perinat Neonatal Nurs	Canfield S. M.; Canada K. E.	Design: Systematic review
97	36729324	Black with 'Baby Blues': A Systematic Scoping Review of Programs to Address Postpartum Depression in African American Women	Matern Child Health J	Robertson K.; Wells R.	Design: Systematic review
98	36841089	Mindfulness-based intervention for clinical and subthreshold perinatal depression and anxiety: A systematic review and meta-analysis of randomized controlled trial	Compr Psychiatry	Leng L. L.; Yin X. C.; Ng S. M.	Design: Systematic review
99	36963518	The effect of mindfulness-based interventions during pregnancy on postpartum mental health: A meta-analysis	J Affect Disord	Min W.; Jiang C.; Li Z.; Wang Z.	Design: Systematic review
100	37000462	Efficacy of nondrug interventions in perinatal depression: A meta-analysis	Psychiatry Res	Jiang X.; Li H.; Wang D.; Shan L.; Wang F.; Kang Y.	Design: Systematic review
101	37029894	Psychodynamic Psychotherapy for Postpartum Depression: A Systematic Review	Matern Child Health J	Valverde N.; Mollejo E.; Legarra L.; Gomez-Gutierrez M.	Design: Systematic review
102	26336787	Yoga for prenatal depression: a systematic review and meta-analysis'	Pract Midwife	Regan M	Design: Systematic review
103	25535930	Effects of Yoga Intervention during Pregnancy: A Review for Current Status	American Journal of Perinatology	Qinxian Jiang; Zhengguo Wu; Li Zhou; Dunlop Jenae; Peijie Chen	Design: Systematic review
104	25896571	Efficacy, Feasibility, and Acceptability of Perinatal Yoga on Women's Mental Health and Well-Being	Journal of Holistic Nursing	Sheffield Karen M.; Woods-Giscombe Cheryl L.	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
105	27118000	An evaluation of perinatal mental health interventions: An integrative literature review	Women & Birth	Lavender Theresa J.; Ebert Lyn; Jones Donovan	Design: Systematic review
106	N/A	Acupuncture versus antidepressants in the management of postpartum depression: A systematic review	British Journal of Midwifery	Komori Akari; Arthur David; Radford Samara; Tan Hsiewe Ying; Zheng Li; An Mira; Umeda Rika; Zheng Zhen	Design: Systematic review
107	N/A	Treating Depression During Pregnancy and the Postpartum: A Preliminary Meta-Analysis	Research on Social Work Practice	Bledsoe Sarah E.; Grote Nancy K.	Design: Systematic review
108	18161036	Psychological treatment of postpartum depression: A meta-analysis	Journal of Clinical Psychology	Cuijpers Pim; Brannmark Jessica G.; van Straten Annemieke	Design: Systematic review
109	N/A	A Systematic Literature Review of Nursing Interventions for Postpartum Depression and their Outcomes	Philippine Journal of Nursing	Peñalba AFNM; Cabrera PNC; Camagong KD; Pagatpatan CP	Design: Systematic review
110	N/A	Efficacy and safety of acupuncture for postpartum depression: A systematic review	Chinese Journal of Evidence-Based Medicine	Cao Y.; Cao W.; Yuan J.; Li M.; Li X.; Yang K.; Wen C.	Design: Systematic review
111	20653342	Management of post traumatic stress disorder after childbirth: A review	Journal of Psychosomatic Obstetrics & Gynecology	Lapp Leann K.; Agbokou Catherine; Peretti Charles-Siegfried; Ferreri Florian	Design: Systematic review
112	28076639	Transcranial magnetic stimulation for treatment of major depression during pregnancy: A review	Trends in Psychiatry and Psychotherapy	Felipe Renata de Melo; Ferrao Ygor Arzeno	Design: Systematic review
113	N/A	Complementary health approaches for postpartum depression: A systematic review	Social Work in Mental Health	McCloskey Rebecca J.; Reno Rebecca	Design: Systematic review
114	34774299	Effect of digital cognitive behavioral therapy on psychological symptoms among perinatal women in high income-countries: A systematic review and meta-regression	Journal of Psychiatric Research	Lau Ying; Yen Kai Yoong; Wong Sai Ho; Cheng Jing Ying; Cheng Ling Jie	Design: Systematic review
115	N/A	Contributing factors, protective elements, and treatments for postpartum PTSD: A systematic review	California Southern University ProQuest Dissertation & Theses	Stelter Mary Pinkerton	Design: Systematic review

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
116	35838293	Clinical practice guidelines with recommendations for peripartum depression: A European systematic review	Acta Psychiatrica Scandinavica	Motrico Emma; Moreno-Peral Patricia; Uriko Kristiina; Hancheva Camellia; Brekalo Maja; Ajaz Erilda; Apter Gisele; Bramante Alessandra; Conejo-Ceron Sonia; Christoforou Andri; Dikmen-Yildiz Pelin; Evagorou Olympia; Fonseca Ana; Lupattelli Angela; Rados Sandra Nakic; al Maach Nadia; Rodriguez-Munoz Marja F.; Lambregtse - van den Berg Mijke P.	Design: Systematic review
117	33580709	Antidepressant treatment for postnatal depression	Cochrane Database of Systematic Reviews	Brown J. V.; Wilson C. A.; Ayre K.; Robertson L.; South E.; Molyneaux E.; Trevillion K.; Howard L. M.; Khalifeh H.	Design: Systematic review
118	N/A	Parent-infant psychotherapy for improving parental and infant mental health	Cochrane Database of Systematic Reviews	Barlow J.; Bennett C.; Midgley N.; Larkin S. K.; Wei Y.	Design: Systematic review
119	32827841	The effectiveness of massage for reducing pregnant women's anxiety and depression; systematic review and meta-analysis	Midwifery	Hall H. G.; Cant R.; Munk N.; Carr B.; Tremayne A.; Weller C.; Fogarty S.; Lauche R.	Design: Systematic review
120	29783936	Identifying and assessing the benefits of interventions for postnatal depression: A systematic review of economic evaluations	BMC Pregnancy and Childbirth	Gurung B.; Jackson L. J.; Monahan M.; Butterworth R.; Roberts T. E.	Design: Systematic review
121	25929986	Postpartum electroconvulsive therapy: a systematic review and case report	Gen Hosp Psychiatry	Gressier F.; Rotenberg S.; Cazas O.; Hardy P.	Design: Systematic review
122	28486363	Effects of Exercise on Mild-to-Moderate Depressive Symptoms in the Postpartum Period: A Meta-analysis	Obstet Gynecol	McCurdy A. P.; Boule N. G.; Sivak A.; Davenport M. H.	Design: Systematic review
123	33340151	Psychological Intervention and Treatment for Posttraumatic Stress Disorder During Pregnancy: A Systematic Review and Call to Action	J Trauma Stress	Stevens N. R.; Miller M. L.; Puetz A. K.; Padin A. C.; Adams N.; Meyer D. J.	Design: Systematic review
124	33533904	Implementation and Effectiveness of Nonspecialist-Delivered Interventions for Perinatal Mental Health in High-Income Countries: A Systematic Review and Meta-analysis	JAMA Psychiatry	Singla D. R.; Lawson A.; Kohrt B. A.; Jung J. W.; Meng Z.; Ratjen C.; Zahedi N.; Dennis C. L.; Patel V.	Design: Systematic review
125	34818326	Early psychological interventions for prevention and treatment of post-traumatic stress disorder (PTSD) and post-traumatic stress symptoms in post-partum women: A systematic review and meta-analysis	PLoS One	Taylor Miller P. G.; Sinclair M.; Gillen P.; McCullough J. E. M.; Miller P. W.; Farrell D. P.; Slater P. F.; Shapiro E.; Klaus P.	Design: Systematic review

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126	N/A	Healthcare interventions for perinatal depression in socially disadvantaged women: A systematic review and meta-analysis	Clinical Psychology: Science and Practice	Rojas-Garcia Antonio; Ruiz-Perez Isabel; Goncalves Daniela C.; Rodriguez-Barranco Miguel; Ricci-Cabello Ignacio	Design: Systematic review
127	21439042	Mums 4 Mums: Structured telephone peer-support for women experiencing postnatal depression. Pilot and exploratory RCT of its clinical and cost effectiveness	Trials	Caramlau I.; Barlow J.; Sembi S.; McKenzie-McHarg K.; McCabe C.	Other...
128	31538488	Effectiveness of a peer support intervention for antenatal depression: a feasibility study	Journal of Reproductive and Infant Psychology	Carter R.; Cust F.; Boath E.	Other...
129	N/A	Transcranial magnetic stimulation for the treatment of major depression during pregnancy: Efficacy and safety of a novel therapeutical strategy	European Neuropsychopharmacology	Arzeno Ferrao Y.; Silva R.; Lieberknecht R.	Not full report (eg, conference abstract)
130	34231203	Interventions for fear of childbirth including tocophobia	Cochrane Database of Systematic Reviews	O'Connell M. A.; Khashan A. S.; Leahy-Warren P.; Stewart F.; O'Neill S. M.	P: Not disorder of interest
131	N/A	Psychosocial and psychological interventions for treating postpartum depression: An updated Cochrane systematic review	Archives of Women's Mental Health	Dennis C. L.; Vigod S. N.; Brown H. K.	Not full report (eg, conference abstract)
132	33247023	Mental health of Urban Mothers (MUM) study: A multicentre randomised controlled trial, study protocol	BMJ Open	Schwank S. E.; Chung H. F.; Hsu M.; Fu S. C.; Du L.; Zhu L.; Huang H. Y.; Andersson E.; Acharya G.	Other...
133	N/A	State of the art and future perspectives on the use of non-invasive neuromodulation in peripartum psychiatric disorders	Encephale	Poleszczyk A.; Kosinska-Kaczynska K.; Avila A. G.; Palm U.; Pereira A. T.; Andrade J.	Not full report (eg, conference abstract)
134	N/A	Early vs. Late wake therapy improves mood in antepartum vs. Postpartum depression by differentially altering melatonin and sleep timing	Sleep	Parry B. L.; Meliska C.; Lopez A.; Sorenson D.; Martinez F.; Orff H.; Hauger R.; Kripke D.	Not full report (eg, conference abstract)
135	N/A	The PRogram in Support of Moms (PRISM): Results of A Cluster Randomized Controlled Trial of Two Active Interventions Addressing Perinatal Depression in Ambulatory Obstetric Settings	Journal of the Academy of Consultation-Liaison Psychiatry	Byatt N.; Brenckle L.; Sankaran P.; Flahive J.; Ko J.; Robbins C. L.; Zimmermann M.; Allison J.; Person S. D.; Simas T. M.	Not full report (eg, conference abstract)
136	8970662	Massage and relaxation therapies' effects on depressed adolescent mothers	Adolescence	Field T.; Grizzle N.; Scafidi F.; Schanberg S.	Not publication year ≥ 2000
137	9099116	A controlled study of fluoxetine and cognitive-behavioural counselling in the treatment of postnatal depression	Bmj	Appleby L.; Warner R.; Whitton A.; Faragher B.	Not publication year ≥ 2000
138	11686971	Caregiver support for postpartum depression	Cochrane Database Syst Rev	Ray K. L.; Hodnett E. D.	Other...

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
139	12655910	The effect of peer support on postpartum depression: a pilot randomized controlled trial	Can J Psychiatry	Dennis C. L.	Duplicate/Secondary analysis (no new data)
140	15973255	A randomized controlled trial of the effects of applied relaxation training on reducing anxiety and perceived stress in pregnant women	J Midwifery Womens Health	Bastani F.; Hidarnia A.; Kazemnejad A.; Vafaei M.; Kashanian M.	S: Not high-income country
141	16420094	Reexamining paroxetine and cognitive-behavioral therapy in postpartum depression and anxiety	J Clin Psychiatry	McClendon J.	D: Not primary study
142	18086500	Postnatal depression and mother and infant outcomes after infant massage	J Affect Disord	O'Higgins M.; St James Roberts I.; Glover V.	I: No intervention of interest
143	19962699	Postpartum depression peer support: maternal perceptions from a randomized controlled trial	Int J Nurs Stud	Dennis C. L.	Other...
144	20361919	Treatment effects of massage therapy in depressed people: a meta-analysis	J Clin Psychiatry	Hou W. H.; Chiang P. T.; Hsu T. Y.; Chiu S. Y.; Yen Y. C.	P: Not population of interest (Not perinatal/Not postpartum)
145	20936338	An open trial of in-home CBT for depressed mothers in home visitation	Matern Child Health J	Ammerman R. T.; Putnam F. W.; Stevens J.; Bosse N. R.; Short J. A.; Bodley A. L.; Van Ginkel J. B.	D: Not RCT
146	21128087	Interventions for the prevention and treatment of postpartum psychosis: a systematic review	Arch Womens Ment Health	Doucet S.; Jones I.; Letourneau N.; Dennis C. L.; Blackmore E. R.	P: Not disorder of interest
147	21153559	An interpersonally based intervention for low-income pregnant women with intimate partner violence: a pilot study	Arch Womens Ment Health	Zlotnick C.; Capezza N. M.; Parker D.	P: Not population of interest (Not perinatal/Not postpartum)
148	21349585	Attitudes and adjustment to the parental role in mothers following treatment for postnatal depression	J Affect Disord	Wan M. W.; Sharp D. J.; Howard L. M.; Abel K. M.	D: Not RCT
149	21439042	Mums 4 Mums: structured telephone peer-support for women experiencing postnatal depression. Pilot and exploratory RCT of its clinical and cost effectiveness	Trials	Caramlau I.; Barlow J.; Sembi S.; McKenzie-McHarg K.; McCabe C.	Duplicate/Secondary analysis (no new data)
150	22401479	The effect of sertraline add-on to brief dynamic psychotherapy for the treatment of postpartum depression: a randomized, double-blind, placebo-controlled study	J Clin Psychiatry	Bloch M.; Meiboom H.; Lorberblatt M.; Bluvstein I.; Aharonov I.; Schreiber S.	I: No intervention of interest
151	22789792	The effects of clinical aromatherapy for anxiety and depression in the high risk postpartum woman - a pilot study	Complement Ther Clin Pract	Conrad P.; Adams C.	Not N ≥10/group

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
152	23177594	A review assessing the current treatment strategies for postnatal psychological morbidity with a focus on post-traumatic stress disorder	Midwifery	Peeler S.; Chung M. C.; Stedmon J.; Skirton H.	P: Not population of interest (Not perinatal/Not postpartum)
153	23855406	The effect of physician-based cognitive behavioural therapy among pregnant women with depressive symptomatology: a pilot quasi-experimental trial	Early Interv Psychiatry	McGregor M.; Coghlan M.; Dennis C. L.	D: Not RCT
154	24604461	Cognitive behavioral therapy in combination with systemic family therapy improves mild to moderate postpartum depression	Braz J Psychiatry	Hou Y.; Hu P.; Zhang Y.; Lu Q.; Wang D.; Yin L.; Chen Y.; Zou X.	S: Not high-income country
155	24788589	Effects of antenatal yoga on maternal anxiety and depression: a randomized controlled trial	Depress Anxiety	Newham J. J.; Wittkowski A.; Hurley J.; Aplin J. D.; Westwood M.	P: Not disorder of interest
156	25074561	Pilot early intervention antenatal group program for pregnant women with anxiety and depression	Arch Womens Ment Health	Thomas N.; Komiti A.; Judd F.	D: Not RCT
157	25277158	Early intervention to protect the mother-infant relationship following postnatal depression: study protocol for a randomised controlled trial	Trials	Milgrom J.; Holt C.	Other...
158	25496615	A randomized controlled trial of the effectiveness of a postnatal psychoeducation programme on self-efficacy, social support and postnatal depression among primiparas	J Adv Nurs	Shorey S.; Chan S. W.; Chong Y. S.; He H. G.	P: Not disorder of interest
159	26385456	A pilot randomized controlled trial comparing prenatal yoga to perinatal health education for antenatal depression	Arch Womens Ment Health	Uebelacker L. A.; Battle C. L.; Sutton K. A.; Magee S. R.; Miller I. W.	Not N ≥10/group
160	26518597	Effects of a midwife psycho-education intervention to reduce childbirth fear on women's birth outcomes and postpartum psychological wellbeing	BMC Pregnancy Childbirth	Fenwick J.; Toohill J.; Gamble J.; Creedy D. K.; Buist A.; Turkstra E.; Sneddon A.; Scuffham P. A.; Ryding E. L.	P: Not disorder of interest
161	26595300	THE EFFECTS OF EXPRESSIVE WRITING ON POSTPARTUM DEPRESSION AND POSTTRAUMATIC STRESS SYMPTOMS	Psychol Rep	Blasio P. D.; Camisasca E.; Caravita S. C.; Ionio C.; Milani L.; Valtolina G. G.	P: Not disorder of interest
162	26887958	Evaluation of an antenatal acupuncture intervention as an adjunct therapy for antenatal depression (AcuAnteDep): study protocol for a pragmatic randomised controlled trial	Trials	Ormsby S. M.; Smith C. A.; Dahlen H. G.; Hay P. J.; Lind J. M.	D: Not primary study
163	26991368	Computer- or web-based interventions for perinatal mental health: A systematic review	J Affect Disord	Ashford M. T.; Olander E. K.; Ayers S.	P: Not population of interest (Not perinatal/Not postpartum)

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164	27238068	Brief Psychotherapy for Maternal Depression: Impact on Mothers and Children	J Am Acad Child Adolesc Psychiatry	Swartz H. A.; Cyranowski J. M.; Cheng Y.; Zuckoff A.; Brent D. A.; Markowitz J. C.; Martin S.; Amole M. C.; Ritchey F.; Frank E.	P: Not population of interest (Not perinatal/Not postpartum)
165	27627126	Effects of relaxation on depression levels in women with high-risk pregnancies: a randomised clinical trial	Rev Lat Am Enfermagem	Arajo W. S.; Romero W. G.; Zandonade E.; Amorim M. H.	P: Not disorder of interest
166	27900745	[The Effects of a Mobile Application Social Support Program on Postpartum Perceived Stress and Depression]	Hu Li Za Zhi	Cheng H. Y.; Huang T. Y.; Chien L. Y.; Cheng Y. F.; Chen F. J.	D: Not RCT
167	28223373	NICU-based Interventions To Reduce Maternal Depressive and Anxiety Symptoms: A Meta-analysis	Pediatrics	Mendelson T.; Cluxton-Keller F.; Vullo G. C.; Tandon S. D.; Noazin S.	P: Not disorder of interest
168	28287802	Depressive symptoms and gestational length among pregnant adolescents: Cluster randomized control trial of CenteringPregnancy- π E plus group prenatal care	J Consult Clin Psychol	Felder J. N.; Epel E.; Lewis J. B.; Cunningham S. D.; Tobin J. N.; Rising S. S.; Thomas M.; Ickovics J. R.	P: Not disorder of interest
169	28455276	Therapist-Supported Internet-Based Cognitive Behavior Therapy for Stress, Anxiety, and Depressive Symptoms Among Postpartum Women: A Systematic Review and Meta-Analysis	J Med Internet Res	Lau Y.; Htun T. P.; Wong S. N.; Tam W. S. W.; Klainin-Yobas P.	P: Not disorder of interest
170	28721461	Influence of adjuvant detached mindfulness and stress management training compared to pharmacologic treatment in primiparae with postpartum depression	Arch Womens Ment Health	Ahmadpanah M.; Nazaribadie M.; Aghaei E.; Ghaleiha A.; Bakhtiari A.; Haghighi M.; Bahmani D. S.; Akhondi A.; Bajoghli H.; Jahangard L.; Holsboer-Trachsler E.; Brand S.	S: Not high-income country
171	28745912	Impact of Psychological Grief Counseling on the Severity of Post-Traumatic Stress Symptoms in Mothers after Stillbirths	Issues Ment Health Nurs	Navidian A.; Saravani Z.; Shakiba M.	S: Not high-income country
172	28750631	Music interventions to reduce stress and anxiety in pregnancy: a systematic review and meta-analysis	BMC Psychiatry	Corbijn van Willenswaard K.; Lynn F.; McNeill J.; McQueen K.; Dennis C. L.; Lobel M.; Alderdice F.	P: Not disorder of interest
173	28855163	Does aerobic exercise reduce postpartum depressive symptoms? a systematic review and meta-analysis	Br J Gen Pract	Pritchett R. V.; Daley A. J.; Jolly K.	P: Not disorder of interest

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
174	28950157	Group-based multicomponent treatment to reduce depressive symptoms in women with co-morbid psychiatric and psychosocial problems during pregnancy: A randomized controlled trial	J Affect Disord	Van Ravesteyn L. M.; Kamperman A. M.; Schneider T. A. J.; Raats M. E.; Steegers E. A. P.; Tiemeier H.; Hoogendijk W. J. G.; Lambregtse-van den Berg M. P.	P: Not disorder of interest
175	28964735	Voluntary running influences the efficacy of fluoxetine in a model of postpartum depression	Neuropharmacology	Gobinath A. R.; Richardson R. J.; Chow C.; Workman J. L.; Lieblich S. E.; Barr A. M.; Galea L. A. M.	I: No intervention of interest
176	28987245	The Effect of Relaxation on Mother's Anxiety and Maternal-Fetal Attachment in Primiparous IVF Mothers	J Natl Med Assoc	Toosi M.; Akbarzadeh M.; Ghaemi Z.	P: Not disorder of interest
177	29357918	Internet-based cognitive behavioural therapy (iCBT) for perinatal anxiety and depression versus treatment as usual: study protocol for two randomised controlled trials	Trials	Loughnan S. A.; Newby J. M.; Haskelberg H.; Mahoney A.; Kladnitski N.; Smith J.; Black E.; Holt C.; Milgrom J.; Austin M. P.; Andrews G.	Not full report (eg, conference abstract)
178	29473698	A proof-of-concept pilot randomized comparative trial of brief Internet-based compassionate mind training and cognitive-behavioral therapy for perinatal and intending to become pregnant women	Clin Psychol Psychother	Kelman A. R.; Evare B. S.; Barrera A. Z.; Munoz R. F.; Gilbert P.	P: Not population of interest (Not perinatal/Not postpartum)
179	29501991	A systematic review and meta-analysis of interpersonal psychotherapy for perinatal women	J Affect Disord	Sockol L. E.	P: Not population of interest (Not perinatal/Not postpartum)
180	29914574	Cognitive-Behavioural therapy and interpersonal psychotherapy for the treatment of post-natal depression: a narrative review	BMC Psychol	Stamou G.; Garcia-Palacios A.; Botella C.	D: Not RCT
181	30303063	Maternal antenatal mood and child development: an exploratory study of treatment effects on child outcomes up to 5 years	J Dev Orig Health Dis	Milgrom J.; Holt C. J.; Bleker L. S.; Holt C.; Ross J.; Ericksen J.; Glover V.; O'Donnell K. J.; de Rooij S. R.; Gemmill A. W.	D: Not primary study
182	30455965	Gender-informed psycho-educational programme to promote respectful relationships and reduce postpartum common mental disorders among primiparous women: long-term follow-up of participants in a community-based cluster randomised controlled trial	Glob Ment Health (Camb)	Fisher J.; Tran T.; Wynter K.; Hiscock H.; Bayer J.; Rowe H.	P: Not population of interest (Not perinatal/Not postpartum)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
183	30717815	Exploring the effect of antenatal depression treatment on children's epigenetic profiles: findings from a pilot randomized controlled trial	Clin Epigenetics	Bleker L. S.; Milgrom J.; Sexton-Oates A.; Roseboom T. J.; Gemmill A. W.; Holt C. J.; Saffery R.; Burger H.; de Rooij S. R.	O: No outcome of interest
184	30982086	Effectiveness of mindfulness-based cognitive therapy for comorbid depression and anxiety in pregnancy: a randomized controlled trial	Arch Womens Ment Health	Zemestani M.; Fazeli Nikoo Z.	S: Not high-income country
185	31199291	Optional Web-Based Videoconferencing Added to Office-Based Care for Women Receiving Psychotherapy During the Postpartum Period: Pilot Randomized Controlled Trial	J Med Internet Res	Yang R.; Vigod S. N.; Hensel J. M.	P: Not disorder of interest
186	31246645	The Effects of Aromatherapy on Postpartum Women: A Systematic Review	J Nurs Res	Tsai S. S.; Wang H. H.; Chou F. H.	P: Not disorder of interest
187	31257092	Transcranial direct current stimulation (tDCS) for depression in pregnancy: A pilot randomized controlled trial	Brain Stimul	Vigod S. N.; Murphy K. E.; Dennis C. L.; Oberlander T. F.; Ray J. G.; Daskalakis Z. J.; Blumberger D. M.	Not N ≥ 10 /group
188	31868776	Preventing Postpartum Depression With Mindful Self-Compassion Intervention: A Randomized Control Study	J Nerv Ment Dis	Guo L.; Zhang J.; Mu L.; Ye Z.	P: Not disorder of interest
189	31960525	Psychological interventions for depression and anxiety in pregnant Latina and Black women in the United States: A systematic review	Clin Psychol Psychother	Ponting C.; Mahrer N. E.; Zelcer H.; Dunkel Schetter C.; Chavira D. A.	P: Not disorder of interest
190	32056815	Effects of yoga on anxiety and depression for high risk mothers on hospital bedrest	Complement Ther Clin Pract	Gallagher A.; Kring D.; Whitley T.	P: Not disorder of interest
191	32116849	Cognitive Behavioral Therapy for Antenatal Depression in a Pilot Randomized Controlled Trial and Effects on Neurobiological, Behavioral and Cognitive Outcomes in Offspring 3-7 Years Postpartum: A Perspective Article on Study Findings, Limitations and Future Aims	Front Psychiatry	Bleker L. S.; Milgrom J.; Sexton-Oates A.; Parker D.; Roseboom T. J.; Gemmill A. W.; Holt C. J.; Saffery R.; Connelly A.; Burger H.; de Rooij S. R.	D: Not primary study
192	32315889	Effects of expressive writing intervention for women's PTSD, depression, anxiety and stress related to pregnancy: A meta-analysis of randomized controlled trials	Psychiatry Res	Qian J.; Zhou X.; Sun X.; Wu M.; Sun S.; Yu X.	P: Not disorder of interest
193	32336122	Psychological or educational eHealth interventions on depression, anxiety or stress following preterm birth: a systematic review	J Reprod Infant Psychol	Feng Y. Y.; Korale-Liyanage S.; Jarde A.; McDonald S. D.	P: Not disorder of interest

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
194	32833477	Protocol for a mechanistic study of mindfulness based cognitive therapy during pregnancy	Health Psychol	Mackiewicz Seghete K. L.; Graham A. M.; Lapidus J. A.; Jackson E. L. A.; Doyle O. J.; Feryn A. B.; Moore L. A.; Goodman S. H.; Dimidjian S.	Not full report (eg, conference abstract)
195	33029304	The effects of PTSD treatment during pregnancy: systematic review and case study	Eur J Psychotraumatol	Baas M. A. M.; van Pampus M. G.; Braam L.; Stramrood C. A. I.; de Jongh A.	P: Not population of interest (Not perinatal/Not postpartum)
196	33180001	A spiritual intervention to reduce stress, anxiety and depression in pregnant women: Randomized controlled trial	Health Care Women Int	Sanaeinasab H.; Saffari M.; Sheykh-Oliya Z.; Khalaji K.; Lalaie A.; Al Zaben F.; Koenig H. G.	S: Not high-income country
197	33220947	A systematic review of clinical effectiveness of psychological interventions to reduce post traumatic stress symptoms following childbirth and a meta-synthesis of facilitators and barriers to uptake of psychological care	J Affect Disord	Slade P. P.; Molyneux D. R.; Watt D. A.	P: Not disorder of interest
198	33630532	Feasibility, Acceptability, and Preliminary Effects of 'Mindful Moms': A Mindful Physical Activity Intervention for Pregnant Women with Depression	Nurs Res	Kinser P. A.; Thacker L. R.; Rider A.; Moyer S.; Amstadter A. B.; Mazzeo S. E.; Bodnar-Deren S.; Starkweather A.	D: Not RCT
199	33879065	Internet-based behavioural activation to improve depressive symptoms and prevent child abuse in postnatal women (SmartMama): a protocol for a pragmatic randomized controlled trial	BMC Pregnancy Childbirth	Obikane E.; Baba T.; Shinozaki T.; Obata S.; Nakanishi S.; Murata C.; Ushio E.; Suzuki Y.; Shirakawa N.; Honda M.; Sasaki N.; Nishi D.; O'Mahen H.; Kawakami N.	D: Not primary study
200	34147932	Efficacy of non-invasive brain stimulation in decreasing depression symptoms during the peripartum period: A systematic review	J Psychiatr Res	Pacheco F.; Guiomar R.; Brunoni A. R.; Buhagiar R.; Evagorou O.; Roca-Lecumberri A.; Poleszczyk A.; Lambregtse-van den Berg M.; Caparros-Gonzalez R. A.; Fonseca A.; Osorio A.; Soliman M.; Ganho-Avila A.	Duplicate/Secondary analysis (no new data)
201	34147972	The effect of music, massage, yoga and exercise on antenatal depression: A meta-analysis	J Affect Disord	Zhu Y.; Wang R.; Tang X.; Li Q.; Xu G.; Zhang A.	P: Not disorder of interest
202	34322621	The influence of mindfulness-based stress reduction (MBSR) on stress, anxiety and depression due to unwanted pregnancy: a randomized clinical trial	J Prev Med Hyg	Nejad F. K.; Shahraki K. A.; Nejad P. S.; Moghaddam N. K.; Jahani Y.; Divsalar P.	P: Not disorder of interest

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
203	34332359	Advancing health through research: A scoping review of and model for adjunctive psychosocial interventions to improve outcomes for perinatal women with bipolar disorder	J Affect Disord	Friedman R.; Giampaolo J.; Vanhaecke L.; Jarrett R. B.	Other...
204	34488847	Postpartum Early EMDR therapy Intervention (PERCEIVE) study for women after a traumatic birth experience: study protocol for a randomized controlled trial	Trials	Hendrix Ymga; van Dongen K. S. M.; de Jongh A.; van Pampus M. G.	D: Not primary study
205	34758210	Peer-Delivered Cognitive-Behavioral Therapy for Postpartum Depression: A Randomized Controlled Trial	J Clin Psychiatry	Amani B.; Merza D.; Savoy C.; Streiner D.; Bieling P.; Ferro M. A.; Van Lieshout R. J.	Duplicate/Secondary analysis (no new data)
206	34867528	Does One Treatment Fit All? Effectiveness of a Multicomponent Cognitive Behavioral Therapy Program in Data-Driven Subtypes of Perinatal Depression	Front Psychiatry	Waqas A.; Rahman A.	S: Not high-income country
207	34894877	Effectiveness of Psychological Interventions to Improve the Mental Well-Being of Parents Who Have Experienced Traumatic Childbirth: A Systematic Review and Meta-Analysis	Trauma Violence Abuse	Shorey S.; Downe S.; Chua J. Y. X.; Byrne S. O.; Fobelets M.; Lalor J. G.	P: Not disorder of interest
208	34914418	Cognitive behavioral stress management effects on prenatal anxiety among low-income women	J Consult Clin Psychol	Ponting C.; Chavira D. A.; Dunkel Schetter C.; Urizar G. G.	P: Not disorder of interest
209	34936270	[Observation on clinical effect of acupuncture combined with wheat-grain moxibustion for mild to moderate postpartum depression]	Zhongguo Zhen Jiu	Lin Y. Y.; Su S. Y.; Lin X. Y.; Jiang F. X.; Xu Y. Y.; Pan S. N.; Zhang X.; Cai H. Q.	S: Not high-income country
210	35112497	Effectiveness of aromatherapy for intrapartum and postpartum emotional problems among parturient women: A meta-analysis of randomized controlled trials	Jpn J Nurs Sci	Hu T. M.; Lee S. H.; Loh E. W.	P: Not disorder of interest
211	35195532	Digitalized Cognitive Behavioral Interventions for Depressive Symptoms During Pregnancy: Systematic Review	J Med Internet Res	Wan Mohd Yunus W. M. A.; Matinolli H. M.; Waris O.; Upadhyaya S.; Vuori M.; Korpilahti-Leino T.; Ristkari T.; Koffert T.; Sourander A.	P: Not disorder of interest
212	35367919	Internet-delivered psychological interventions for reducing depressive, anxiety symptoms and fear of childbirth in pregnant women: A meta-analysis and meta-regression	J Psychosom Res	Neo H. S.; Tan J. H.; Ang W. H. D.; Lau Y.	P: Not disorder of interest
213	35413533	Emphasizing mindfulness training in acceptance relieves anxiety and depression during pregnancy	Psychiatry Res	Yang M.; Zhou X.; Ye C.; Li J.; Sun S.; Yu X.	S: Not high-income country

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
214	35440458	Protocol for the Healing After Loss (HeAL) Study: a randomised controlled trial of interpersonal psychotherapy (IPT) for major depression following perinatal loss	BMJ Open	Johnson J. E.; Price A. B.; Sikorskii A.; Key K. D.; Taylor B.; Lamphere S.; Huff C.; Cinader M.; Zlotnick C.	Not full report (eg, conference abstract)
215	35699314	Cognitive behavioral therapy in perinatal mental health: An overview of systematic reviews	Jpn J Nurs Sci	Okatsau A.; Aoyama S.; Yamaji N.; Kataoka Y.	P: Not disorder of interest
216	35876837	Sustained remission from perinatal depression after bright light therapy: A pilot randomised, placebo-controlled trial	Acta Psychiatr Scand	Garbazza C.; Cirignotta F.; D'Agostino A.; Cicolin A.; Hackethal S.; Wirz-Justice A.; Cajochen C.; Manconi M.	P: Not disorder of interest
217	35910879	Reliability of Evidence to Guide Decision-Making in the Use of Acupuncture for Postpartum Depression	Front Public Health	Hu X.; Fan Q.; Ma L.; Jin R.; Gong R.; Zhao X.; Qiu F.; Zhou L.	S: Not high-income country
218	36049141	Smartphone-assisted online brief cognitive behavioral therapy to treat maternal depression: findings of a randomized controlled trial	Braz J Psychiatry	Fatori D.; Zuccolo P.; Xavier M. O.; Matijasevich A.; Polanczyk G. V.	S: Not high-income country
219	36189185	The Impact of a Mindfulness App on Postnatal Distress	Mindfulness (N Y)	Bear K. A.; Barber C. C.; Medvedev O. N.	P: Not disorder of interest
220	36276421	Interventions to improve social support among postpartum mothers: A systematic review	Health Promot Perspect	Sharifipour F.; Javadnoori M.; Behboodi Moghadam Z.; Najafian M.; Cheraghian B.; Abbaspoor Z.	P: Not disorder of interest
221	36327004	The impact of maternal depression on child mental health treatment and models for integrating care: a systematic review	Arch Womens Ment Health	Engelhard C.; Hishinuma E.; Rehuher D.	P: Not population of interest (Not perinatal/Not postpartum)
222	36478339	Culturally adapted psychological intervention for treating maternal depression in British mothers of African and Caribbean origin: A randomized controlled feasibility trial	Clin Psychol Psychother	Jidong D. E.; Ike J. T.; Husain N.; Murshed M.; Francis C.; Mwankon B. S.; Jack B. D.; Jidong J. E.; Pwajok Y. J.; Nyam P. P.; Kiran T.; Bassett P.	P: Not population of interest (Not perinatal/Not postpartum)
223	36586616	Critically-timed sleep and light interventions differentially improve mood in pregnancy vs. postpartum depression by shifting melatonin rhythms	J Affect Disord	Parry B. L.; Meliska C. J.; Sorenson D. L.; Martinez L. F.; Lopez A. M.; Dawes S. E.; Elliott J. A.; Hauger R. L.	Other...
224	36871401	Systematic review and meta-analysis of psychoeducation on the psychological and social impact among first-time mothers	Patient Educ Couns	Ong Q. O.; Ong J. W.; Ang M. Q.; Vehvilainen-Julkunen K.; He H. G.	P: Not population of interest (Not perinatal/Not postpartum)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
225	36873226	Art-based interventions for women's mental health in pregnancy and postpartum: A meta-analysis of randomised controlled trials	Front Psychiatry	Qian J.; Sun S.; Wang M.; Sun X.; Yu X.	P: Not population of interest (Not perinatal/Not postpartum)
226	36991389	Effectiveness of cognitive behavioural therapy-based interventions for maternal perinatal depression: a systematic review and meta-analysis	BMC Psychiatry	Pettman D.; O'Mahen H.; Blomberg O.; Svanberg A. S.; von Essen L.; Woodford J.	Duplicate/Second ary analysis (no new data)
227	36997966	Effect of Remote Peer-Counsellor- delivered Behavioral Activation and Peer-support for Antenatal Depression on Gestational Age at Delivery: a single-blind, randomized control trial	Trials	Chaput K. H.; Freeman M.; McMorris C.; Metcalfe A.; Cameron E. E.; Jung J.; Tough S.; Hicks L. M.; Dimidjian S.; Tomfohr-Madsen L. M.	Other...
228	25369906	Depression improvement and parenting in low-income mothers in home visiting	Archives of Women's Mental Health	Ammerman Robert; Altaye Mekibib; Putnam Frank; Teeters Angelique; Zou Yuanshu; Ginkel Judith	Duplicate/Second ary analysis (no new data)
229	24598825	Feasibility and efficacy of an internet treatment for postnatal depression utilising a behavioural activation approach	Evidence Based Nursing	Milgrom Jeannette; Gemmill Alan	Not full report (eg, conference abstract)
230	22789792	The effects of clinical aromatherapy for anxiety and depression in the high risk postpartum woman ,Äi A pilot study	Complementary Therapies in Clinical Practice	Conrad Pam; Adams Cindy	Duplicate/Second ary analysis (no new data)
231	22532053	Trajectories of long-term outcomes for postnatally depressed mothers treated with group interpersonal psychotherapy	Archives of Women's Mental Health	Reay Rebecca; Owen Cathy; Shadbolt Bruce; Raphael Beverley; Mulcahy Rhiannon; Wilkinson Ross	Duplicate/Second ary analysis (no new data)
232	21720793	Group treatment for postpartum depression: a systematic review	Archives of Women's Mental Health	Goodman Janice; Santangelo Gabrielle	Duplicate/Second ary analysis (no new data)
233	20860888	A pragmatic randomised controlled trial to compare antidepressants with a community-based psychosocial intervention for the treatment of women with postnatal depression: the RESPOND trial	Health Technology Assessment	Sharp Dj; Chew-Graham C.; Tylee A.; Lewis G.; Howard L.; Anderson I.; Abel K.; Turner K.; Hollinghurst S.; Tallon D.; McCarthy A.; Peters T.	Duplicate/Second ary analysis (no new data)
234	19633250	Telephone based peer support can reduce postnatal depression in women at high risk	Evidence-based Mental Health	Matthey S.	Not full report (eg, conference abstract)
235	19633251	Training health visitors to identify and treat depressive symptoms with psychological approaches reduces postnatal depression	Evidence-based Mental Health	Dennis C.	Not full report (eg, conference abstract)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
236	19697094	A randomised control [sic] trial for the effectiveness of group interpersonal psychotherapy for postnatal depression	Archives of Women's Mental Health	Mulcahy R.; Reay R. E.; Wilkinson R. B.; Owen C.	Duplicate/Secondary analysis (no new data)
237	19962699	Postpartum depression peer support: maternal perceptions from a randomized controlled trial	International Journal of Nursing Studies	Dennis C.	Duplicate/Secondary analysis (no new data)
238	23904069	Interventions (other than pharmacological, psychosocial or psychological) for treating antenatal depression	Cochrane Database of Systematic Reviews	Dennis C.; Dowswell T.	Duplicate/Secondary analysis (no new data)
239	18669682	Six-month multicomponent intervention improves postnatal depression in low-income settings	Evidence-based Mental Health	Zayas L. H.	Not full report (eg, conference abstract)
240	18669681	Review: psychosocial and psychological interventions reduce postpartum depressive symptoms	Evidence-based Mental Health	Abel K. M.	Not full report (eg, conference abstract)
241	17636841	Psychosocial and psychological interventions for treating antenatal depression	Cochrane Database of Systematic Reviews	Dennis C.; Ross L. E.; Grigoriadis S.	Duplicate/Secondary analysis (no new data)
242	17943888	Psychosocial and psychological interventions for treating postpartum depression	Cochrane Database of Systematic Reviews	Dennis C.; Hodnett E. D.	Duplicate/Secondary analysis (no new data)
243	16638899	Counselling and cognitive behavioural therapy reduce anxiety and depression in women with postnatal depression	Evidence-based Mental Health	Dennis C.	Not full report (eg, conference abstract)
244	25062520	Early Intervention in Pregnant Women With Elevated Anxiety and Depressive Symptoms	Journal of Perinatal & Neonatal Nursing	Bittner Antje; Peukert Judith; Zimmermann Cornelia; Junge-Hoffmeister Juliane; Parker Lisa S.; Stobel-Richter Yve; Weidner Kerstin	Duplicate/Secondary analysis (no new data)
245	25804297	A pragmatic randomized controlled trial to evaluate the effectiveness of a facilitated exercise intervention as a treatment for postnatal depression: the PAMPeRS trial	Psychological Medicine	Daley A. J.; Blamey R. V.; Jolly K.; Roalfe A. K.; Turner K. M.; Coleman S.; McGuinness M.; Jones I.; Sharp D. J.; MacArthur C.	Duplicate/Secondary analysis (no new data)
246	111864890. Language:	Postnatal. A systematic review of psychosocial interventions for women with postpartum stress	MIDIRS Midwifery Digest	Ju-Eun Song; Kim Tiffany; Ahn Jeong-Ah	P: Not population of interest (Not perinatal/Not postpartum)
247	27003141	Interpersonal psychotherapy (IPT) for major depression following perinatal loss: a pilot randomized controlled trial	Archives of Women's Mental Health	Johnson Jennifer; Price Ann; Kao Jennifer; Fernandes Karen; Stout Robert; Gobin Robyn; Zlotnick Caron	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
248	28855163	Does aerobic exercise reduce postpartum depressive symptoms? A systematic review and meta-analysis	MIDIRS Midwifery Digest	Pritchett Ruth Victoria; Daley Amanda J.; Jolly Kate	Duplicate/Secondary analysis (no new data)
249	N/A	Effectiveness of acupuncture as an add-on treatment for women with postnatal depression: a systematic review	Women & Birth	Wang Carol; Bayes Sara	Not full report (eg, conference abstract)
250	31246645	The Effects of Aromatherapy on Postpartum Women: A Systematic Review	Journal of Nursing Research (Lippincott Williams & Wilkins)	Tsai Shuo-Shin; Wang Hsiu-Hung; Chou Fan-Hao	Duplicate/Secondary analysis (no new data)
251	32629701	Role of psychotherapy on antenatal depression, anxiety, and maternal quality of life: A meta-analysis	Medicine	Caixia Li; Xiaohua Sun; Qing Li; Qian Sun; Beibei Wu; Dongyun Duan; Li Caixia; Sun Xiaohua; Li Qing; Sun Qian; Wu Beibei; Duan Dongyun	Duplicate/Secondary analysis (no new data)
252	34749125	The effectiveness of psychological interventions for pregnant women with anxiety in the antenatal period: A systematic review	Midwifery	Callanan Fiona; Tuohy Teresa; Bright Ann-Marie; Grealish Annmarie	Duplicate/Secondary analysis (no new data)
253	N/A	Mindfulness- and Compassion-Based Parenting Interventions Applied to the Postpartum Period: A Systematic Review	Journal of Child & Family Studies	Fernandes Daniela V.; Martins Ana R.; Canavarro Maria C.; Moreira Helena	P: Not population of interest (Not perinatal/Not postpartum)
254	35195532	Digitalized Cognitive Behavioral Interventions for Depressive Symptoms During Pregnancy: Systematic Review	Journal of Medical Internet Research	Yunus Wan Mohd Azam Wan Mohd; Matinolli Hanna-Maria; Waris Otto; Upadhyaya Subina; Vuori Miika; Korpilahti-Leino Tarja; Ristkari Terja; Koffert Tarja; Sourander Andre; Wan Mohd Yunus Wan Mohd Azam	Duplicate/Secondary analysis (no new data)
255	33706830	Unexpected effects of expressive writing on post-disaster distress in the Hurricane Harvey Study: a randomized controlled trial in perinatal women	Psychological Medicine	Paquin Vincent; Bick Johanna; Lipschutz Rebecca; Elgbeili Guillaume; Laplante David P.; Biekman Brian; Brunet Alain; King Suzanne; Olson David	Duplicate/Secondary analysis (no new data)
256	12724244	Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression 1 Impact on maternal mood	The British Journal of Psychiatry	Cooper Peter J.; Murray Lynne; Wilson Anji; Romaniuk Helena	Duplicate/Secondary analysis (no new data)
257	12724245	Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression 2 Impact on the mother--child relationship and child outcome	The British Journal of Psychiatry	Murray Lynne; Cooper Peter J.; Wilson Anji; Romaniuk Helena	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
258	N/A	Prevention and treatment of post partum depression: A controlled study	Devenir	Chabrol Henri; Teissedre Frederique; Saint-Jean Michele; Teisseyre Nathalie; Roge Bernadette	Duplicate/Secondary analysis (no new data)
259	15367052	The Use of Paroxetine and Cognitive-Behavioral Therapy in Postpartum Depression and Anxiety: A Randomized Controlled Trial	The Journal of Clinical Psychiatry	Misri Shaila; Reebye Pratibha; Corral Maria; Mills Lisa	Duplicate/Secondary analysis (no new data)
260	N/A	A Controlled Clinical Trial of Citalopram and Citalopram Combined with Psychotherapy in the Treatment of Postpartum Depression	Chinese Mental Health Journal	Chun-Liu Qiu; Bo Xiao; Wen-Jiao Xie	S: Not high-income country
261	28636219	A mother-infant therapy group model for postpartum depression	Infant Mental Health Journal	Clark Roseanne; Tluczek Audrey; Brown Roger	D: Not RCT
262	N/A	A physician-based Cognitive Behavioral Intervention for depressed pregnant women in primary care: A pilot study		McGregor Marla Louise	D: Not RCT
263	21535997	A randomized, double-blind, placebo-controlled study of light therapy for antepartum depression	The Journal of Clinical Psychiatry	Wirz-Justice Anna; Bader Anja; Frisch Ulrike; Stieglitz Rolf-Dieter; Alder Judith; Bitzer Johannes; Hosli Irene; Jazbec Sandra; Benedetti Francesco; Terman Michael; Wisner Katherine L.; Riecher-Rossler Anita	Duplicate/Secondary analysis (no new data)
264	22840621	Randomized non-invasive sham-controlled pilot trial of electroacupuncture for postpartum depression	Journal of Affective Disorders	Chung Ka-Fai; Yeung Wing-Fai; Zhang Zhang-Jin; Yung Kam-Ping; Man Sui-Cheung; Lee Chin-Peng; Lam Siu-Keung; Leung Tsin-Wah; Leung Kwok-Yin; Ziea Eric Tat-Chi; Wong Vivian Taam	Duplicate/Secondary analysis (no new data)
265	23602514	Internet-based behavioral activation treatment for postnatal depression (Netmums): A randomized controlled trial	Journal of Affective Disorders	O'Mahen Heather A.; Woodford Joanne; McGinley Julia; Warren Fiona C.; Richards David A.; Lynch Thomas R.; Taylor Rod S.	Duplicate/Secondary analysis (no new data)
266	25074561	Pilot early intervention antenatal group program for pregnant women with anxiety and depression': Erratum	Archives of Women's Mental Health	Thomas Naomi; Komiti Angela; Judd Fiona	Duplicate/Secondary analysis (no new data)
267	N/A	The feasibility of yoga in the treatment of antenatal depression and anxiety: A pilot study	Doctoral dissertation, Thesis Master	Davis Kyle J.	Other...

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
268	25886805	Efficacy of yoga for depressed postpartum women: A randomized controlled trial	Complement Ther Clin Pract	Buttner Melissa Mercedes	Duplicate/Secondary analysis (no new data)
269	26261095	Performance of a culturally tailored cognitive behavioral intervention integrated in a public health setting to reduce risk of antepartum depression: A randomized controlled trial	Journal of Midwifery & Women's Health	Jesse D. Elizabeth; Gaynes Bradley N.; Feldhousen Elizabeth B.; Newton Edward R.; Bunch Shelia; Hollon Steven D.	Duplicate/Secondary analysis (no new data)
270	26551600	A long-term follow-up study of a randomized controlled trial of mother-infant psychoanalytic treatment: Outcomes on mothers and interactions	Infant Mental Health Journal	Salomonsson Majlis Winberg; Sorjonen Kimmo; Salomonsson Bjorn	P: Not population of interest (Not perinatal/Not postpartum)
271	27152849	Internet-provided cognitive behaviour therapy of posttraumatic stress symptoms following childbirth a randomized controlled trial	Cognitive Behaviour Therapy	Nieminen Katri; Berg Ida; Frankenstein Katri; Viita Lina; Larsson Kamilla; Persson Ulrika; Spanberger Loviisa; Wretman Anna; Silfvernagel Kristin; Andersson Gerhard; Wijma Klaas	Duplicate/Secondary analysis (no new data)
272	27627126	Effects of relaxation on depression levels in women with high-risk pregnancies: A randomised clinical trial	Revista Latino-Americana de Enfermagem	de Arajo Wanda Scherrer; Romero Walckiria Garcia; Zandonade Eliana; Costa Amorim Maria Helena	Duplicate/Secondary analysis (no new data)
273	28137316	A pilot randomized controlled trial of time-intensive cognitive behaviour therapy for postpartum obsessive-compulsive disorder: Effects on maternal symptoms, mother-infant interactions and attachment	Psychological Medicine	Challacombe F. L.; Salkovskis P. M.; Woolgar M.; Wilkinson E. L.; Read J.; Acheson R.	Duplicate/Secondary analysis (no new data)
274	N/A	The role of engagement in mindfulness-based cognitive therapy for the prevention of depressive relapse/recurrence in perinatal women	Mindfulness	Evans Amanda P. B.; Goodman Sherryl H.; Dimidjian Sona; Gallop Robert	D: Not RCT
275	31550613	The short- and long-term effectiveness of mother-infant psychotherapy on postpartum depression: A systematic review and meta-analysis	Journal of Affective Disorders	Huang Ruirui; Yang Dongqi; Lei Beimei; Yan Chunli; Tian Yumei; Huang Xin; Lei Jun	Duplicate/Secondary analysis (no new data)
276	0	Decentering and self-compassion: A randomized controlled trial of target engagement in mindful mood balance for moms		Metcalf Christina A.	D: Not RCT
277	32563204	Effectiveness of cognitive behavioural therapy for perinatal depression: A systematic review and meta-analysis	Journal of Clinical Nursing	Li Zimeng; Liu Ying; Wang Jiayao; Liu Jia; Zhang Chunmei; Liu Yanhui	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
278	33949762	Mother matters: Pilot randomized wait-list controlled trial of an online therapist-facilitated discussion board and support group for postpartum depression symptoms	Depression and Anxiety	Vigod Simone N.; Slyfield Cook Greer; Macdonald Kaeli; Hussain-Shamsy Neesha; Brown Hilary K.; de Oliveira Claire; Torshizi Kiana; Benipal Pardeep K.; Grigoriadis Sophie; Classen Catherine C.; Dennis Cindy-Lee	Duplicate/Secondary analysis (no new data)
279	N/A	Meta-analysis of the effectiveness of biological and non-biological treatments for postpartum depression	ProQuest Dissertation & Theses	Christian Sarah Jeung soon	Other...
280	N/A	Baby worries: A randomized controlled trial of mother-infant psychoanalytic treatment	ProQuest Dissertation & Theses	Salomonsson Bjorn	P: Not population of interest (Not perinatal/Not postpartum)
281	37310303	Psychological treatment of perinatal depression: A meta-analysis	Psychological Medicine	Cuijpers Pim; Franco Pamela; Ciharova Marketa; Miguel Clara; Segre Lisa; Quero Soledad; Karyotaki Eirini	D: Not RCT
282	34495285	Effect of online 1-day cognitive behavioral therapy based workshops plus usual care vs usual care alone for postpartum depression: A randomized clinical trial	JAMA Psychiatry	Van Lieshout Ryan J.; Layton Haley; Savoy Calan D.; Brown June S. L.; Ferro Mark A.; Streiner David L.; Bieling Peter J.; Feller Andrea; Hanna Steven	Duplicate/Secondary analysis (no new data)
283	34495285	Effect of online 1-day cognitive behavioral therapy based workshops plus usual care vs usual care alone for postpartum depression: A randomized clinical trial': Correction	JAMA Psychiatry	Van Lieshout Ryan J.; Layton Haley; Savoy Calan D.; Brown June S. L.; Ferro Mark A.; Streiner David L.; Bieling Peter J.; Feller Andrea; Hanna Steven	Duplicate/Secondary analysis (no new data)
284	N/A	Examining the acceptability and effectiveness of transdiagnostic, internet-delivered cognitive behaviour therapy for symptoms of postpartum anxiety and depression: A randomized controlled trial	ProQuest Dissertation & Theses	Suchan Victoria Ayla Mary	D: Not RCT
285	N/A	Personalized exploration of mindfulness-based intervention on antenatal depression: Moderated mediation analyses of a randomized controlled trial	Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues	Sun Yaoyao; Wang Juan; Mao Fangxiang; Sun Jiwei; Zhang Xuan; Cao Fenglin	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
286	35876837	Sustained remission from perinatal depression after bright light therapy: A pilot randomised, placebo controlled trial	Acta Psychiatrica Scandinavica	Garbazza Corrado; Cirignotta Fabio; D'Agostino Armando; Cicolin Alessandro; Hackethal Sandra; Wirz-Justice Anna; Cajochen Christian; Manconi Mauro	Duplicate/Secondary analysis (no new data)
287	31960525	Psychological interventions for pregnant Black women and Latinas with depression or anxiety	Clin Psychol Psychother	Ponting Carolyn Michelle	Duplicate/Secondary analysis (no new data)
288	36174135	Culturally sensitive psychotherapy for perinatal women: A mixed methods study	Journal of Consulting and Clinical Psychology	Singla Daisy R.; Hossain Sabrina; Andrejek Nicole; Cohen Matthew J.; Dennis Cindy-Lee; Kim Jo; La Porte Laura; Meltzer-Brody Samantha E.; Puerto Nino Angie; Ravitz Paula; Schoueri-Mychasiw Nour; Silver Richard; Vigod Simone N.; Zibaman Maral; Schiller Crystal E.	D: Not RCT
289	N/A	Mindfulness interventions to reduce prenatal stress and anxiety in pregnant patients		Sitjar Maricris T.	P: Not population of interest (Not perinatal/Not postpartum)
290	36504355	The effectiveness of psychological interventions for anxiety in the perinatal period: A systematic review and meta-analysis	Psychology and Psychotherapy: Theory, Research and Practice	Clinkscales Natalie; Golds Lisa; Berlouis Katherine; MacBeth Angus	Duplicate/Secondary analysis (no new data)
291	36478339	Culturally adapted psychological intervention for treating maternal depression in british mothers of african and caribbean origin: A randomized controlled feasibility trial	Clinical Psychology & Psychotherapy	Jidong Dung Ezekiel; Ike Juliet Tarela; Husain Nusrat; Murshed Maisha; Francis Christopher; Mwankon B. Shadrack; Jack B. David; Jidong John Ezekiel; Pwajok Y. Juliet; Nyam P. Pam; Kiran Tayyaba; Bassett Paul	Duplicate/Secondary analysis (no new data)
292	36700350	Associations between maternal postpartum depression and infant temperament in treatment-seeking mothers prior to and during the covid-19 pandemic	Development and Psychopathology	Chang Oswin; Huh Kathryn; Savoy Calan D.; Krzeczkowski John E.; Van Lieshout Ryan J.	D: Not RCT
293	36423436	Internet-delivered mindfulness-based interventions for mental health outcomes among perinatal women: A systematic review	Asian Journal of Psychiatry	Mao Fangxiang; Sun Yaoyao; Li Yang; Cui Naixue; Cao Fenglin	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
294	36878891	In-person 1-day cognitive behavioral therapy-based workshops for postpartum depression: A randomized controlled trial	Psychological Medicine	Van Lieshout Ryan J.; Layton Haley; Savoy Calan D.; Xie Feng; Brown June S. L.; Huh Kathryn; Bieling Peter J.; Streiner David L.; Ferro Mark A.; Haber-Evans Erika	Duplicate/Secondary analysis (no new data)
295	17943888	Psychosocial and psychological interventions for treating postpartum depression	Cochrane Database of Systematic Reviews	Dennis C. L.; Hodnett E. D.	Duplicate/Secondary analysis (no new data)
296	9099116	A controlled study of fluoxetine and cognitive-behavioral counselling in the treatment of postnatal depression	BMJ (Clinical research ed.)	Appleby L.; Warner Rwhitton Afaragher B.	D: Not RCT
297	11963345	Detection, prevention and treatment of postpartum depression: a randomized, controlled study on a sample of 859 women	Encephale	Chabrol H.; Teissedre F.; Saint-Jean M.; Teisseire N.; Sistac C.; Michaud C.; Roge B.	Duplicate/Secondary analysis (no new data)
298	15265228	The effectiveness of a pram-walking exercise programme in reducing depressive symptomatology for postnatal women	International journal of nursing practice	Armstrong K.; Edwards H.	Not N ≥10/group
299	15973255	A randomized controlled trial of the effects of applied relaxation training on reducing anxiety and perceived stress in pregnant women	Journal of midwifery & women's health	Bastani F.; Hidarnia A.; Kazemnejad A.; Vafaei M.; Kashanian M.	P: Not population of interest (Not perinatal/Not postpartum)
300	20177281	Acupuncture for depression during pregnancy: a randomized controlled trial	Obstetrics and gynecology	Manber R.; Schnyer R. N.; Lyell D.; Chambers A. S.; Caughey A. B.; Druzin M.; Carlyle E.; Celio C.; Gress J. L.; Huang M. I.; et al.	Duplicate/Secondary analysis (no new data)
301	N/A	Acupuncture for depression during pregnancy	American journal of obstetrics and gynecology	Manber R.; Schnyer R.; Chambers A.; Lyell D.; Caughey A.; Carlyle E.	Not full report (eg, conference abstract)
302	N/A	A randomised controlled trial of cognitive therapy for antenatal depression	Controlled-trials.com	Evans J.	Not full report (eg, conference abstract)
303	20860888	A pragmatic randomised controlled trial to compare antidepressants with a community-based psychosocial intervention for the treatment of women with postnatal depression: the RESPOND trial	Health technology assessment (Winchester, England)	Sharp D. J.; Chew-Graham C.; Tylee A.; Lewis G.; Howard L.; Anderson I.; Abel K.; Turner K. M.; Hollinghurst S. P.; Tallon D.; et al.	Duplicate/Secondary analysis (no new data)
304	N/A	Acupuncture for depression during pregnancy: a controlled randomized trial	Revista internacional de acupuntura	Ortiz M.	Not full report (eg, conference abstract)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
305	21535997	A randomized, double-blind, placebo-controlled study of light therapy for antepartum depression	Journal of clinical psychiatry	Wirz-Justice A.; Bader A.; Frisch U.; Stieglitz R. D.; Alder J.; Bitzer J.; Hosli I.; Jazbec S.; Benedetti F.; Terman M.; et al.	Duplicate/Secondary analysis (no new data)
306	22840621	Randomized non-invasive sham-controlled pilot trial of electroacupuncture for postpartum depression	Journal of affective disorders	Chung K. F.; Yeung W. F.; Zhang Z. J.; Yung K. P.; Man S. C.; Lee C. P.; Lam S. K.; Leung T. W.; Leung K. Y.; Ziea E. T.; et al.	Duplicate/Secondary analysis (no new data)
307	20936338	An open trial of in-home CBT for depressed mothers in home visitation	Maternal and child health journal	Ammerman R. T.; Putnam F. W.; Stevens J.; Bosse N. R.; Short J. A.; Bodley A. L.	Duplicate/Secondary analysis (no new data)
308	N/A	Effect of exercise program on symptoms of postpartum depression	Iranian journal of obstetrics, gynecology and infertility	Saeedi S.	S: Not high-income country
309	N/A	Efficacy of yoga for depressed postpartum women: a randomized controlled trial	Dissertation abstracts international: section B: the sciences and engineering dissertation abstracts international	Buttner Melissa Mercedes	Other...
310	N/A	Multidisciplinary model of nurse midwife administered psychotherapy for postpartum depression	Archives of women's mental health	Posmontier B.; Stuart S.; Neugebauer R.; Shaughnessy R.	Not full report (eg, conference abstract)
311	N/A	Effectiveness of cognitive-behavioral stress management intervention on anxiety and depression during pregnancy	Journal of kerman university of medical sciences	Karamoozian M.; Askarizadeh G.	S: Not high-income country
312	N/A	The feasibility of yoga in the treatment of antenatal depression and anxiety: a pilot study	Dissertation abstracts international: section B: the sciences and engineering dissertation abstracts international	Davis Kyle J.	Duplicate/Secondary analysis (no new data)
313	N/A	Anticipate: a pilot randomised trial of CBT for antenatal depression and validation of depression screening by midwives	Archives of women's mental health	Evans J.; Noble A.; Baxter H.; Bennert K.; O'Mahen H.; Turner K.; Ramchandani P.; Wiles N.; Sharp D.	Not full report (eg, conference abstract)
314	N/A	Synthesis: bright morning light therapy for antenatal depression	Archives of women's mental health	Wisner K. L.; Sit D. K. Y.	Not full report (eg, conference abstract)
315	N/A	Momcare: culturally relevant treatment services for perinatal depression	Archives of women's mental health	Grote N.; Katon W.; Lohr M. J.	Not full report (eg, conference abstract)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
316	N/A	Preliminary results of cognitive behavioral stress management (CBSM) on cortisol levels among low-income pregnant women: the smart MOMS project	Psychosomatic medicine	Urizar G.; Yim I. S.; Schetter C. D.	Not full report (eg, conference abstract)
317	N/A	A pilot randomized controlled trial of cognitive behavioural therapy for women with antenatal depression: infant temperament and sleep	Archives of women's mental health	Netsi E.; Jonathan E.; Heather O.; Alison B.; Paul R.	Not full report (eg, conference abstract)
318	N/A	Cognitive behavioral therapy for treatment of antenatal anxiety and depressive symptoms: a randomized controlled trial	Archives of women's mental health	Beijers C.; Verbeek T.; Van Pampus M. G.; Meijer J. L.; Burger H.; Bockting C. L. H.	Not full report (eg, conference abstract)
319	N/A	Multidisciplinary model of nurse midwife administered psychotherapy for postpartum depression	Archives of women's mental health	Posmontier B.; Neugebauer R.; Stuart S.; Shaughnessy R.; Chittams J.	Not full report (eg, conference abstract)
320	N/A	A multi-site randomized controlled trial to evaluate the effect of telephone-based interpersonal psychotherapy by trained nurses for the treatment of postpartum depression	Archives of women's mental health	Dennis C. L.; Ravitz P.; Grigoriadis S.; Jovellanos M.; Hodnett E.; Ross L.; Zupancic J.	Not full report (eg, conference abstract)
321	N/A	Interactions and attachment in infants of mothers with OCD	Archives of women's mental health	Challacombe F.; Salkovskis P.; Woolgar M.	Not full report (eg, conference abstract)
322	N/A	CBT for low income perinatal women	Archives of women's mental health	Mahen H. O.; Himle J.; Fedoc G.; Flynn H.	Not full report (eg, conference abstract)
323	N/A	Pilot results on child outcomes of antenatal depression treatment	Archives of women's mental health	Milgrom J.; Holt C.; Schembri C.; Gemmill A.	Not full report (eg, conference abstract)
324	N/A	Exercise as an adjunct therapy for postnatal depression: a pilot study	Archives of women's mental health	Boath E.; Henshaw C.; Forsyth J.	Not full report (eg, conference abstract)
325	N/A	Development of a CBT program for depression during pregnancy-beating the blues before birth	Archives of women's mental health	Milgrom J.; Holt C.; Schembri C.; Gemmill A.	Not full report (eg, conference abstract)
326	26595300	THE EFFECTS OF EXPRESSIVE WRITING ON POSTPARTUM DEPRESSION AND POSTTRAUMATIC STRESS SYMPTOMS	Psychological reports	Blasio P. D.; Camisasca E.; Caravita S. C.; Ionio C.; Milani L.; Valtolina G. G.	Duplicate/Secondary analysis (no new data)
327	26385456	A pilot randomized controlled trial comparing prenatal yoga to perinatal health education for antenatal depression	Arch women's mental health	Uebelacker Lisa A.; Battle Cynthia L.; Sutton Kaeli A.; Magee Susanna R.; Miller Ivan W.	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
328	25804297	A pragmatic randomized controlled trial to evaluate the effectiveness of a facilitated exercise intervention as a treatment for postnatal depression: the PAM-PeRS trial	Psychological medicine	Daley A. J.; Blamey R. V.; Jolly K.; Roalfe A. K.; Turner K. M.; Coleman S.; McGuinness M.; Jones I.; Sharp D. J.; MacArthur C.	Duplicate/Secondary analysis (no new data)
329	25062520	Early intervention in pregnant women with elevated anxiety and depressive symptoms: efficacy of a cognitive-behavioral group program	Journal of perinatal & neonatal nursing	Bittner A.; Peukert J.; Zimmermann C.; Junge-Hoffmeister J.; Parker L. S.; Stobel-Richter Y.; Weidner K.	Duplicate/Secondary analysis (no new data)
330	28045285	A pragmatic randomized clinical trial of behavioral activation for depressed pregnant women	Journal of consulting and clinical psychology	Dimidjian S.; Goodman S. H.; Sherwood N. E.; Simon G. E.; Ludman E.; Gallop R.; Welch S. S.; Boggs J. M.; Metcalf C. A.; Hubley S.; et al.	Duplicate/Secondary analysis (no new data)
331	28258027	Impact of an educational DVD on anxiety and glycaemic control in women diagnosed with gestational diabetes mellitus (GDM): a randomised controlled trial	Diabetes research and clinical practice	Draffin C. R.; Alderdice F. A.; McCance D. R.; Maresh M.; Harper R.; Patterson C. C.; Bernatavicius G.; Brennan S. F.; Gough A.; McSorley O.; et al.	P: Not disorder of interest
332	28287802	Depressive Symptoms and Gestational Length Among Pregnant Adolescents: cluster Randomized Control Trial of Centering Pregnancy Plus Group Prenatal Care	Journal of consulting and clinical psychology. (no pagination), 2017	Felder J. N.; Epel E.; Lewis J. B.; Cunningham S. D.; Tobin J. N.; Rising S. S.; Thomas M.; Ickovics J. R.	Duplicate/Secondary analysis (no new data)
333	27821114	Bright light therapy in pregnant women with major depressive disorder: study protocol for a randomized, double-blind, controlled clinical trial	BMC psychiatry	Bais B.; Kamperman A. M.; van der Zwaag M. D.; Dieleman G. C.; Harmsen van der Vliet-Torij H. W.; Bijma H. H.; Lieveerse R.; Hoogendijk W. J.; Lambregtse-van den Berg M. P.	Other...
334	28721461	Influence of adjuvant detached mindfulness and stress management training compared to pharmacologic treatment in primiparae with postpartum depression	Archives of women's mental health	Ahmadpanah M.; Nazariabadie M.; Aghaei E.; Ghaleiha A.; Bakhtiari A.; Haghighi M.; Bahmani D. S.; Akhondi A.; Bajoghli H.; Jahangard L.; et al.	Duplicate/Secondary analysis (no new data)
335	28593360	Strongest Families™ Managing Our Mood (MOM): a randomized controlled trial of a distance intervention for women with postpartum depression	Archives of women's mental health	Wozney L.; Olthuis J.; Lingley-Pottie P.; McGrath P. J.; Chaplin W.; Elgar F.; Cheney B.; Huguet A.; Turner K.; Kennedy J.	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
336	28614554	Efficacy of a Maternal Depression Prevention Strategy in Head Start: a Randomized Clinical Trial	JAMA psychiatry	Silverstein M.; Diaz-Linhart Y.; Cabral H.; Beardslee W.; Hegel M.; Haile W.; Sander J.; Patts G.; Feinberg E.	P: Not disorder of interest
337	N/A	Early vs. Late wake therapy improves mood in antepartum vs. Postpartum depression by differentially altering melatonin and sleep timing	Journal of affective disorders	Parry, B.L., Meliska, C.J., Lopez, A.M., Sorenson, D.L., Martinez, L.F., Orff, H.J., Hauger, R.L. and Kripke, D.F	Duplicate/Second ary analysis (no new data)
338	N/A	The effectiveness of relaxation techniques on depression, anxiety and stress in pregnant women: based on self-efficacy theory	Scientific journal of kurdistan university of medical sciences	Alipoor M.; Ghahremani L.; Amooee S.; Keshavarzi S.	S: Not high-income country
339	28482901	Prenatal listening to songs composed for pregnancy and symptoms of anxiety and depression: a pilot study	BMC complementary and alternative medicine	Nwebube C.; Glover V.; Stewart L.	P: Not disorder of interest
340	27152849	Internet-provided cognitive behaviour therapy of posttraumatic stress symptoms following childbirth-a randomized controlled trial	Cognitive behaviour therapy	Nieminen K.; Berg I.; Frankenstein K.; Viita L.; Larsson K.; Persson U.; Spanberger L.; Wretman A.; Silfvernagel K.; Andersson G.; et al.	Duplicate/Second ary analysis (no new data)
341	28628768	Internet delivered cognitive behavior therapy for antenatal depression: a randomised controlled trial	Journal of affective disorders	Forsell E.; Bendix M.; Hollandare F.; Szymanska von Schultz B.; Nasiell J.; Blomdahl-Wetterholm M.; Eriksson C.; Kvarneld S.; Lindau van der Linden J.; Soderberg E.; et al.	Duplicate/Second ary analysis (no new data)
342	29413138	Mitigating the effect of persistent postnatal depression on child outcomes through an intervention to treat depression and improve parenting: a randomised controlled trial	The lancet. Psychiatry	Stein A.; Netsi E.; Lawrence P. J.; Granger C.; Kempton C.; Craske M. G.; Nickless A.; Mollison J.; Stewart D. A.; Rapa E.; et al.	Duplicate/Second ary analysis (no new data)
343	27480668	Using Prenatal Advocates to Implement a Psychosocial Education Intervention for Posttraumatic Stress Disorder during Pregnancy: feasibility, Care Engagement, and Predelivery Behavioral Outcomes	Women's health issues	Upshur C. C.; Wenz-Gross M.; Weinreb L.; Moffitt J. J. A.	Duplicate/Second ary analysis (no new data)
344	N/A	Cognitive Behavioural Group Therapy for Perinatal Anxiety	https://clinicaltrials.gov/show/NCT02850523	Nct	O: No results reported (registry)
345	N/A	Randomised Control Trial of a Complex Intervention for Postnatal Depression	https://clinicaltrials.gov/show/NCT01309516	Nct	O: No results reported (registry)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
346	N/A	Mother-Infant Intervention for Postpartum Depression and Associated Mother-Infant Relationship Dysfunction	https://clinicaltrials.gov/show/NCT02057627	Nct	O: No results reported (registry)
347	N/A	Telephone-based cognitive-behavioral therapy on postnatal depression and quality of life	BJOG	Ngai F. W.	Not full report (eg, conference abstract)
348	30266030	A randomized controlled trial of 'MUMentum Pregnancy': internet-delivered cognitive behavioral therapy program for antenatal anxiety and depression	Journal of affective disorders	Loughnan S. A.; Sie A.; Hobbs M. J.; Joubert A. E.; Smith J.; Haskelberg H.; Mahoney A. E. J.; Kladnitski N.; Holt C. J.; Milgrom J.; et al.	Duplicate/Secondary analysis (no new data)
349	N/A	Culturally relevant psychotherapy for perinatal depression	Archives of women's mental health	Grote N. K.; Swartz H. A.; Geibel S.; Frank E.	Not full report (eg, conference abstract)
350	N/A	Psychological treatment of antenatal depression and anxiety: effects on obstetric outcomes	Archives of women's mental health	Verbeek T.; Ci L. H.; Meijer J. L.; Beijers C.; Van Pampus M. G.; Burger H.	Not full report (eg, conference abstract)
351	N/A	TCM acupuncture provides clinically relevant improvement in depression during pregnancy	Focus on alternative and complementary therapies	Lee H.	Not full report (eg, conference abstract)
352	N/A	Psychological treatment of antenatal depression and anxiety: effects on obstetric outcomes	Archives of women's mental health	Verbeek T.; Bockting C. L. H.; Meijer J. L.; Beijers C.; Van Pampus M. G.; Burge H.	Duplicate/Secondary analysis (no new data)
353	N/A	80: effects of cognitive behavioural therapy for antenatal anxiety and depression on mother and offspring	American journal of obstetrics and gynecology	Burger H.; Verbeek T.; Meijer J.; Beijers C.; Mol B.; Ormel J.; van Pampus M.; Bockting C.	Not full report (eg, conference abstract)
354	30877878	A randomised controlled trial of 'MUMentum postnatal': internet-delivered cognitive behavioural therapy for anxiety and depression in postpartum women	Behaviour research and therapy	Loughnan S. A.; Butler C.; Sie A. A.; Grierson A. B.; Chen A. Z.; Hobbs M. J.; Joubert A. E.; Haskelberg H.; Mahoney A.; Holt C.; et al.	Duplicate/Secondary analysis (no new data)
355	N/A	Influence of adjuvant detached mindfulness and stress management training compared to pharmacologic treatment in primiparae with postpartum depression	Pharmacopsychiatry	Sadeghi Bahmani D.; Ahmadpanah M.; Haghighi M.; Akhondi A.; Ghaleiha A.; Jahangard L.; Holsboer-Trachsler S.	Duplicate/Secondary analysis (no new data)
356	N/A	Influence of adjuvant metacognitive detached mindfulness and stress management training compared to pharmacologic treatment in primiparae with postpartum depression	Swiss medical weekly	Brand S.; Ahmadpanah M.; Haghighi M.; Sadeghi Bahmani D.; Holsboer-Trachsler E.	Duplicate/Secondary analysis (no new data)
357	N/A	Light Therapy for Depression During Pregnancy	https://clinicaltrials.gov/show/NCT01043289	Nct	O: No results reported (registry)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
358	31805778	The EMDR Recent Birth Trauma Protocol: a pilot randomised clinical trial after traumatic childbirth	Psychology & health	Chiorino V.; Cattaneo M. C.; Macchi E. A.; Salerno R.; Roveraro S.; Bertolucci G. G.; Mosca F.; Fumagalli M.; Cortinovis I.; Carletto S.; et al.	Duplicate/Secondary analysis (no new data)
359	N/A	Mood and sleep improvement with critically-timed wake and light interventions in premenstrual, peripartum vs. perimenopausal depression depend on specific underlying melatonin and sleep circadian phase disturbances	Sleep medicine	Parry B.; Meliska C.; Sorenson D.; Martinez F.; Lopez A.; Dawes S.; Hauger R.; Kripke D.	Not full report (eg, conference abstract)
360	N/A	The evaluation of acupuncture as an adjunct intervention for antenatal depression: a pragmatic randomised controlled trial	Journal of alternative and complementary medicine (New York, N.Y.)	Ormsby S.; Smith C.; Dahlen H.; Hay P.	Other...
361	N/A	Critically-timed wake and light therapy: mood effects on premenstrual, peripartum and menopausal depression depend on melatonin-sleep timing	Neuropsychobiology	Parry B.; Meliska C.; Sorenson D.; Martinez L. F.; Lopez A.; Dawes S.; Hauger R.; Kripke D.	Not full report (eg, conference abstract)
362	N/A	Mindfulness-based Intervention for Postnatal Depression	https://clinicaltrials.gov/show/NCT04332146	Nct	O: No results reported (registry)
363	N/A	Regaining MUMentum: findings from two randomized controlled trials evaluating brief internet cognitive behavioral therapy for perinatal distress, anxiety, and depression	Archives of women's mental health	Loughnan S.	Not full report (eg, conference abstract)
364	N/A	Regaining 'MUMentum': randomized controlled trial of online CBT for perinatal distress, anxiety, and depression	Archives of women's mental health	Loughnan Sa- M.; Newby J.; Andrews G.; Butler C.	Not full report (eg, conference abstract)
365	N/A	Maternal antenatal mood and child development: an exploratory study of treatment effects on child outcomes up to 5 years	Archives of women's mental health	Milgrom J.; Holt C. J.; Bleker L.; Holt C.; Ross J.; Ericksen J.; Glover V.; O'Donnell K. J.; De Rooij S.; Gemmill A. W.	Duplicate/Secondary analysis (no new data)
366	31823163	The Effect of Expressive Writing on Postpartum Depression and Stress of Mothers with a Preterm Infant in NICU	Journal of clinical psychology in medical settings	Rabiepoor S.; Vatankhah-Alamdary N.; Khalkhali H. R.	S: Not high-income country
367	32409986	A pilot study of a group-based perinatal depression intervention on reducing depressive symptoms and improving maternal-fetal attachment and maternal sensitivity	Archives of women's mental health	Alhusen J. L.; Hayat M. J.; Borg L.	Duplicate/Secondary analysis (no new data)
368	N/A	Treatment of Intrapartum Depression Using Non-invasive Photobiomodulation	https://clinicaltrials.gov/show/NCT04404231	Nct	O: No results reported (registry)
369	N/A	Light Therapy to Improve Symptoms in Pregnant Women With Major Depressive Disorder	https://clinicaltrials.gov/show/NCT04447430	Nct	O: No results reported (registry)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
370	N/A	The effect of writing therapy on anxiety in pregnant women: a randomized controlled trial	Iranian journal of psychiatry and behavioral sciences	Montazeri M.; Esmailpour K.; Mohammad-Alizadeh-Charandabi S.; Golizadeh S.; Mirghafourvand M.	S: Not high-income country
371	N/A	Treatment for antenatal anxiety and depression with Beating the Blues before Birth BBB positively impacts infant postnatal development at 9 months, a pilot RCT	Archives of women's mental health	Ericksen J.; Milgrom J.; Holt C.; Ross J.; Gemmill A.	Not full report (eg, conference abstract)
372	N/A	Internet cognitive behavioural therapy for women with postnatal depression: a randomized controlled trial of MumMoodBooster	Archives of women's mental health	Milgrom J.; Danaher B. G.; Gemmill A. W.; Holt C.; Holt C. J.; Seeley J. R.; Tyler M. S.; Ross J.; Ericksen J.	Duplicate/Secondary analysis (no new data)
373	N/A	Early intervention to protect the mother-infant relationship following postnatal depression: a randomised controlled trial	Archives of women's mental health	Milgrom J.; Holt C.; Gemmill A. W.; Ericksen J.	Not full report (eg, conference abstract)
374	32116849	Cognitive Behavioral Therapy for Antenatal Depression in a Pilot Randomized Controlled Trial and Effects on Neurobiological, Behavioral and Cognitive Outcomes in Offspring 3, 7 Years Postpartum: a Perspective Article on Study Findings, Limitations and Future Aims	Frontiers in psychiatry	Bleker L. S.; Milgrom J.; Sexton-Oates A.; Parker D.; Roseboom T. J.; Gemmill A. W.; Holt C. J.; Saffery R.; Connelly A.; Burger H.; et al.	Duplicate/Secondary analysis (no new data)
375	N/A	Peer support for antenatal depression (AND): a feasibility study for a randomised controlled trial	Journal of reproductive and infant psychology	Boath E.; Cust F.; Carter R.	Not full report (eg, conference abstract)
376	33949762	Mother Matters: pilot randomized wait-list controlled trial of an online therapist-facilitated discussion board and support group for postpartum depression symptoms	Depression and anxiety	Vigod S. N.; Slyfield Cook G.; Macdonald K.; Hussain-Shamsy N.; Brown H. K.; de Oliveira C.; Torshizi K.; Benipal P. K.; Grigoriadis S.; Classen C. C.; et al.	Duplicate/Secondary analysis (no new data)
377	N/A	Online Peer-Delivered 1-Day CBT Workshops for PPD	https://clinicaltrials.gov/show/NCT04934488	Nct	O: No results reported (registry)
378	N/A	LTP and CBT for Treating Postnatal Depression in British Mothers of African and Caribbean Origin	https://clinicaltrials.gov/show/NCT05148260	Nct	O: No results reported (registry)
379	34914418	Cognitive Behavioral Stress Management Effects on Prenatal Anxiety Among Low-Income Women	Journal of consulting and clinical psychology	Ponting C.; Chavira D. A.; Schetter C. D.; Urizar G. G.	Duplicate/Secondary analysis (no new data)
380	35842616	Web-based treatment for depression in pregnancy: a feasibility study of Mum2BMoodBooster	BMC psychiatry	Gemmill A. W.; Oliva J. L.; Ericksen J.; Holt C.; Holt C. J.; Milgrom J.	D: Not RCT

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
381	N/A	Yoga exercises can reduce prenatal maternal stress	European psychiatry	Kiselev S.	Not full report (eg, conference abstract)
382	36478339	Culturally adapted psychological intervention for treating maternal depression in British mothers of African and Caribbean origin: a randomised controlled feasibility trial	Clinical psychology & psychotherapy	Ezekiel J. D.; Tarela I. J.; Nusrat H.; Maisha M.; Christopher F.; Shadrack M. B.; David J. B.; Ezekiel J. J.; Juliet P. Y.; Pam N. P.; et al.	Duplicate/Secondary analysis (no new data)
383	36586616	Critically-timed sleep and light interventions differentially improve mood in pregnancy vs. postpartum depression by shifting melatonin rhythms	Journal of affective disorders	Parry B. L.; Meliska C. J.; Sorenson D. L.; Martinez L. F.; Lopez A. M.; Dawes S. E.; Elliott J. A.; Hauger R. L.	Duplicate/Secondary analysis (no new data)
384	N/A	Effects of support group intervention in postnatally distressed women: a controlled study in Taiwan		Chen C.; Tseng Y.; Chou F.; Wang S.	S: Not high-income country
385	26571104	Clinical management of perinatal anxiety disorders: A systematic review	J Affect Disord	Marchesi C.; Ossola P.; Amerio A.; Daniel B. D.; Tonna M.; De Panfilis C.	Other...
386	27182732	The Effectiveness of Mindfulness-Based Interventions in the Perinatal Period: A Systematic Review and Meta-Analysis	PLoS One	Lever Taylor B.; Cavanagh K.; Strauss C.	P: Not population of interest (Not perinatal/Not postpartum)
387	27539908	The effects of mindfulness interventions on prenatal well-being: A systematic review	Psychol Health	Matvienko-Sikar K.; Lee L.; Murphy G.; Murphy L.	P: Not disorder of interest
388	34555958	Effects of maternal stress and/or anxiety interventions in the first 1000 days: Systematic review of reviews	Journal of Reproductive & Infant Psychology	Matvienko-Sikar Karen; Redsell Sarah; Flannery Caragh	Other...
389	15367053	Treatment of Postpartum Depression, Part 1: A Critical Review of Biological Interventions	The Journal of Clinical Psychiatry	Dennis Cindy-Lee E.; Stewart Donna E.	Duplicate/Secondary analysis (no new data)
390	15367054	Treatment of Postpartum Depression, Part 2: A Critical Review of Nonbiological Interventions	The Journal of Clinical Psychiatry	Dennis Cindy-Lee E.	Duplicate/Secondary analysis (no new data)
391	21735413	Mind-body interventions during pregnancy for preventing or treating women's anxiety	Cochrane Database of Systematic Reviews	Marc I.; Toureche N.; Ernst E.; Hodnett E. D.; Blanchet C.; Dodin S.; Njaya M. M.	Duplicate/Secondary analysis (no new data)
392	33580709	Antidepressant treatment for postnatal depression	Cochrane database of systematic reviews (Online)	Brown J. V. E.; Wilson C. A.; Ayre K.; South E.; Molyneaux E.; Trevillion K.; Howard L. M.; Khalifeh H.	Duplicate/Secondary analysis (no new data)

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
393	28994626	PRogram In Support of Moms (PRISM): a pilot group randomized controlled trial of two approaches to improving depression among perinatal women	Journal of psychosomatic obstetrics and gynaecology	Byatt N.; Moore Simas T. A.; Biebel K.; Sankaran P.; Pbert L.; Weinreb L.; Ziedonis D.; Allison J.	I: No intervention of interest
394	12655910	The effect of peer support on postpartum depression: A pilot randomized controlled trial	Canadian Journal of Psychiatry	Dennis C. L.	P: Not disorder of interest
395	21385294	Effect of home-based peer support on maternal-infant interactions among women with postpartum depression: A randomized, controlled trial	International Journal of Mental Health Nursing	Letourneau Nicole; Stewart Miriam; Dennis Cindy-Lee; Hegadoren Kathleen; Duffett-Leger Linda; Watson Barry	Duplicate/Secondary analysis (no new data)
396	36360528	Effectiveness of a Mobile Application for Postpartum Depression Self-Management: Evidence from a Randomised Controlled Trial in South Korea	Healthcare (2227-9032)	Seo Ji-Min; Kim Su-Jeong; Na Hyunjoo; Kim Jin-Hee; Lee Hyejin	P: Not disorder of interest
397	N/A	Preventing Depressive Relapse in Pregnant Women With Recurrent Depression	https://clinicaltrials.gov/show/NCT03623620	Nct	
398	31121887	Brain Magnetic Resonance Imaging Findings in Children after Antenatal Maternal Depression Treatment, a Longitudinal Study Built on a Pilot Randomized Controlled Trial	Int J Environ Res Public Health	Bleker L. S.; Milgrom J.; Parker D.; Gemmill A. W.; Holt C. J.; Connelly A.; Burger H.; Roseboom T. J.; de Rooij S. R.	Other...
399	15715034	Massage therapy effects on depressed pregnant women	J Psychosom Obstet Gynaecol	Field T.; Diego M. A.; Hernandez-Reif M.; Schanberg S.; Kuhn C.	Other...
400	26261095	Performance of a Culturally Tailored Cognitive-Behavioral Intervention Integrated in a Public Health Setting to Reduce Risk of Antepartum Depression: A Randomized Controlled Trial	J Midwifery Womens Health	Jesse D. E.; Gaynes B. N.; Feldhousen E. B.; Newton E. R.; Bunch S.; Hollon S. D.	P: Not disorder of interest
401	24061387	Brief Internet-based intervention reduces posttraumatic stress and prolonged grief in parents after the loss of a child during pregnancy: a randomized controlled trial	Psychother Psychosom	Kersting A.; Dolemeier R.; Steinig J.; Walter F.; Kroker K.; Baust K.; Wagner B.	P: Not population of interest (Not perinatal/Not postpartum)
402	10986574	The impact of partner support in the treatment of postpartum depression	Can J Psychiatry	Misri S.; Kostaras X.; Fox D.; Kostaras D.	Other...
403	11246096	Infant massage improves mother-infant interaction for mothers with postnatal depression	J Affect Disord	Onozawa K.; Glover V.; Adams D.; Modi N.; Kumar R. C.	I: No intervention of interest
404	25522664	Perinatal Dyadic Psychotherapy for postpartum depression: a randomized controlled pilot trial	Arch Womens Ment Health	Goodman J. H.; Prager J.; Goldstein R.; Freeman M.	I: No intervention of interest
405	33742282	Improving the mother-infant relationship following postnatal depression: a randomised controlled trial of a brief intervention (HUGS)	Arch Womens Ment Health	Holt C.; Gentileau C.; Gemmill A. W.; Milgrom J.	I: No intervention of interest

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
406	24778436	A pilot randomised controlled trial to evaluate the feasibility and acceptability of the Baby Triple P Positive Parenting Programme in mothers with postnatal depression	Clin Child Psychol Psychiatry	Tsivos Z. L.; Calam R.; Sanders M. R.; Wittkowski A.	I: No intervention of interest
407	N/A	Effects of mindfulness-based cognitive therapy in pregnancy on psychological distress and gestational age: Outcomes of a randomized controlled trial	Mindfulness	MacKinnon Anna L.; Madsen Joshua W.; Giesbrecht Gerald F.; Campbell Tavis; Carlson Linda E.; Dimidjian Sona; Letourneau Nicole; Tough Suzanne; Tomfohr-Madsen Lianne	P: Not disorder of interest
408	19083666	Massage therapy reduces pain in pregnant women, alleviates prenatal depression in both parents and improves their relationships	J Bodyw Mov Ther	Field T.; Figueiredo B.; Hernandez-Reif M.; Diego M.; Deeds O.; Ascencio A.	I: No intervention of interest
409	25016216	Culturally relevant treatment services for perinatal depression in socio-economically disadvantaged women: the design of the MOMCare study	Contemp Clin Trials	Grote N. K.; Katon W. J.; Lohr M. J.; Carson K.; Curran M.; Galvin E.; Russo J. E.; Gregory M.	I: No intervention of interest
410	26345179	COLLABORATIVE CARE FOR PERINATAL DEPRESSION IN SOCIOECONOMICALLY DISADVANTAGED WOMEN: A RANDOMIZED TRIAL	Depress Anxiety	Grote N. K.; Katon W. J.; Russo J. E.; Lohr M. J.; Curran M.; Galvin E.; Carson K.	I: No intervention of interest
411	28076671	A Randomized Trial of Collaborative Care for Perinatal Depression in Socioeconomically Disadvantaged Women: The Impact of Comorbid Posttraumatic Stress Disorder	J Clin Psychiatry	Grote N. K.; Katon W. J.; Russo J. E.; Lohr M. J.; Curran M.; Galvin E.; Carson K.	I: No intervention of interest
412	29678804	Feasibility and Acceptability of a Web-Based Treatment with Telephone Support for Postpartum Women With Anxiety: Randomized Controlled Trial	JMIR Ment Health	Ashford M. T.; Olander E. K.; Rowe H.; Fisher J. R.; Ayers S.	P: Not disorder of interest
413	19616143	Effects of home-based exercise on fatigue in postpartum depressed women: who is more likely to benefit and why?	Journal of psychosomatic research	Dritsa M.; Dupuis G.; Lowensteyn I.; Da Costa D.	O: No outcome of interest
414	17459185	Effective treatment for postpartum depression is not sufficient to improve the developing mother-child relationship	Dev Psychopathol	Forman D. R.; O'Hara M. W.; Stuart S.; Gorman L. L.; Larsen K. E.; Coy K. C.	I: No intervention of interest
415	37074698	Effect of Brief Interpersonal Therapy on Depression During Pregnancy: A Randomized Clinical Trial	JAMA Psychiatry	Hankin B. L.; Demers C. H.; Hennessey E. P.; Perzow S. E. D.; Curran M. C.; Gallop R. J.; Hoffman M. C.; Davis E. P.	I: No intervention of interest

Number	PubMed ID	Title	Journal	Authors	Rejection Reason
416	31726954	Randomized controlled trial of the Circle of Security-Intensive intervention for mothers with postpartum depression: maternal unresolved attachment moderates changes in sensitivity	Attach Hum Dev	Ramsauer B.; Muhlhan C.; Lotzin A.; Achtergarde S.; Mueller J.; Krink S.; Tharner A.; Becker-Stoll F.; Nolte T.; Romer G.	I: No intervention of interest
417	36371154	Effect of internet-based cognitive behaviour therapy among women with negative birth experiences on mental health and quality of life - a randomized controlled trial	BMC Pregnancy Childbirth	Sjomark J.; Svanberg A. S.; Larsson M.; Viirman F.; Poromaa I. S.; Skalkidou A.; Jonsson M.; Parling T.	P: Not disorder of interest
418	N/A	Effects of Exercise on Women With Postpartum Depression: A Systematic Review of the Literature	N/A	Adams V.; Volo J.; Burnside A.; Cross J.; Kalafut M.; Figuers C.	Unable to retrieve full text
419	N/A	A randomized, double-blind controlled clinical trial of light therapy for pregnant women with major depressive disorder	NEUROPSYCHOBIOLOGY	Bais B.	Unable to retrieve full text
420	11963345	[Detection, prevention and treatment of postpartum depression: a controlled study of 859 patients]	Encephale	Chabrol H.; Teissedre F.; Saint-Jean M.; Teisseyre N.; Sistac C.; Michaud C.; Roge B.	P: Not disorder of interest
421	29383894	[Effects of Transcutaneous Electrical Acupoint Stimulation for Depression in Late Pregnancy and Impacts on Inflammatory Cytokines]	Zhen Ci Yan Jiu	Chen W. Y.; Li L.; Wang H. Y.; Jiang N.	Unable to retrieve full text
422	32503517	Online yoga to reduce post traumatic stress in women who have experienced stillbirth: a randomized control feasibility trial	BMC Complement Med Ther	Huberty J.; Sullivan M.; Green J.; Kurka J.; Leiferman J.; Gold K.; Cacciatore J.	P: Not population of interest (Not perinatal/Not postpartum)
423	N/A	Screening, prevention and postpartum treatment: a randomized comparative study on 450 women	Screening, prevention and postpartum treatment: a randomized comparative study on 450 women	Teissedre F.; Chabrol H.	P: Not disorder of interest
424	N/A	Effect of acupuncture plus psychological intervention on 5-HT, OFQ and E2 in Patients with postpartum depression	Shanghai Journal of Acupuncture and Moxibustion	Xi Y. X.; Wang Y.	Unable to retrieve full text
425	N/A	Therapeutic efficacy of acupuncture at the thirteen ghost points for postpartum depression and its effect on the quality of life	Shanghai Journal of Acupuncture and Moxibustion	Yu S. J.; Li X. Q.; Feng X. M.; Cao W. F.	Unable to retrieve full text

Appendix C. Evidence Map Tables, Study Design, and Baseline Tables

Table C-1. KQ 1: Evidence map

Study	Mental Health Condition (Inclusion Criteria)	Perinatal Period	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
Chabrol, 2002, 12214785	Depressive disorder (EPDS \geq 11, MINI)	Postpartum/ Postnatal	CBT + Psychoeducation (N=18)	TAU (N=30)	Recovery rates based on HDRS scores of <7 and BDI scores of <4 were also significantly greater in the treated group than in the control group.
Buttner, 2015, 25886805	Depressive Disorder (HADS \geq 12)	Postpartum/ Postnatal	Yoga (N = 28)	Waitlist control (N = 29)	Depressive symptoms, anxiety symptoms, and health related quality of life were significantly improved in the yoga group, compared with the control group at the end of treatment.
Challacombe, 2024, 37848088	Anxiety disorder (DSM-5)	Antenatal/ Prenatal	Time-intensive delivery of CBT (INT-CBT) (N= 29)	Standard weekly one-hour CBT sessions (WCBT) (N= 30)	Women receiving INT-CBT showed a reduction in anxiety (GAD-7) after two weeks of treatment compared to WCBT with narrower difference at 3-month postpartum.
Cluxton-Keller, 2023, 37921846	Depressive disorder (BDI-II \geq 20)	Antenatal/ Prenatal	Experimental family therapeutic intervention, Resilience Enhancement Skills Training (REST) (N=42)	Standard of care (Videoconferencing technology (VCT)-based problem-solving individual therapy) (N=41)	The results showed that REST is safe for perinatal women with moderate to severe depressive symptoms, and none discontinued due to worsened depressive symptoms. REST is well tolerated by families, and no families discontinued due to sustained family conflict.
Evans, 2021, 34649534	Depressive disorders (CIS-R, EPDS \geq 10)	Antenatal/ Prenatal	IPT + Interpersonal counseling (N=26)	CBT (N=26)	There was improvement in mood in both groups rated by change in EPDS score.
Fancourt, 2018, 29436333	Depression (EPDS \geq 10)	Postpartum/ Postnatal	Singing (N=30)	Playgroup (N=23), TAU (N=22)	There was a nonsignificant faster improvement in symptoms in the singing group ($p = 0.16$). When isolating mothers with moderate–severe symptoms of PND, this result became significant, with a faster improvement in symptoms in the singing group ($p = 0.033$).
Field, 2009, 19761951	Depressive disorders (SCID)	Antenatal/ Prenatal	IPT + Massage (N= NR)	IPT (N =NR)	The group who received both therapies also showed a greater decrease in depression, depressed affect and somatic vegetative symptom scores on CES-D, a greater decrease in anxiety scale (STAI) scores and a greater decrease in cortisol levels.

Study	Mental Health Condition (Inclusion Criteria)	Perinatal Period	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
Field, 2013, 23727060	Depressive disorders (NR)	Antenatal/ Prenatal	IPT (N=22)	Peer support (N= 22)	Both groups had lower summary depression (CES-D) scores and lower anxiety (STAI) scores by the end of the treatment period. Cortisol levels decreased for both groups after the last day session, although the decrease was greater for the peer support group. The groups did not differ on neonatal outcomes including gestational age and birthweight.
Field, 2013, 24138994	Depressive disorders (SCID)	Antenatal/ Prenatal	Yoga (N =46)	Peer support group (N= 46)	No significant difference in anxiety, depression, anger and quality of relationship scores between yoga and peer support at the end of treatment.
Gjerdingen, 2013, 23799688	Depression (PHQ-9 \geq 10)	Postpartum/ Postnatal	Postpartum doula support (N=12), Peer telephone support (N=12)	TAU (N=14)	The postpartum doula group, compared with the other 2 groups, had a higher proportion of women with a previous history of depression, and similarly, a higher proportion of women who were depressed and receiving depression treatment at the 6-month follow-up. Satisfaction with study-sponsored support was greater in the postpartum doula group than in the telephone support group.
Hamilton, 2021, 32997871	Depression and Anxiety (HADS >10)	Antenatal/ Prenatal	Cognitive analytic therapy + TAU (N= 20)	TAU (N= 19)	Mean STAT state score was lower in CAT + TAU group compared to TAU at 24 weeks after randomization. Patient retention was high for the CAT group.
Heller, 2020, 32202505	Depression or Anxiety (CES-D: 16, HADS \geq 8)	Perinatal/ Peripartum	Problem solving therapy (N=79)	TAU (N=80)	Both groups showed a substantial decrease in affective symptoms on the CES-D, HADS-A, and EPDS over time. In the intervention group, affective symptoms decreased more than that in the control group. Negative perinatal child outcomes did not differ between the 2 groups.
Horwitz, 2015, 25452159	Depression, Anxiety, PTSD (BDI \geq 20, BAI \geq 16)	Postpartum/ Postnatal	CBT (trauma focused) (N=62)	Psychoeducation (N=43)	The perceptions of infants' vulnerability showed significant declines, with no differences across groups or in rate of change. Mothers reporting prior trauma at entry to the study showed much lower perceptions of infants' vulnerability scores under the intervention ($p = .01$).
Johnson, 2016, 27003141	Depressive disorders	Postpartum/ Postnatal	IPT (N=25)	Psychoeducation (N=25)	End of treatment satisfaction scores were significantly ($p = .001$) higher in IPT than in

Study	Mental Health Condition (Inclusion Criteria)	Perinatal Period	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
	(SCID)				CWD. Confidence interval around between-groups effect sizes favored IPT for reductions in depressive symptoms during treatment, as well as for improvement in mode-specific targets (social support, grief symptoms) and recovery from posttraumatic stress disorder over follow-up.
Kim, 2019, 30249416	Depressive disorders (SCID, HAM-D ≥ 18)	Antenatal/ Prenatal	transcranial magnetic stimulation (TMS) (N=11)	eSham (N=11)	Right-sided, low frequency TMS was effective in reducing depressive symptoms. Response and remission rates were not significantly different.
Kozinszky, 2012, 22261988	Depressive disorder (Levertton Questionnaire; LQ)	Postpartum/ Postnatal	CBT + IPT + Psychoeducation (N= 93)	TAU (N= 181)	The intervention appeared to significantly reduce the risk of PPD, as defined by Levertton Questionnaire total scores.
Letourneau, 2011, 21385294	Depressive disorders (EPDS >12)	Postpartum/ Postnatal	Peer support (N=27)	TAU (N=33)	A significant difference between the groups was observed for one of the two measures of maternal–infant interactions. Several other measures favored the control group, including mothers’ depressive symptoms and social support scores. No significant treatment effects were observed in infant IQ scores or diurnal salivary cortisol levels in mothers or infants.
Milgrom, 2021, 34889742	Depressive disorders (SCID, EPDS-Anxiety subscale)	Postpartum/ Postnatal	MumMoodBooster (MMB) (N=39), Face to face therapy (N=39)	TAU (N=38)	MMB performed at least as well as face to face CBT (P<0.05). MBB also significantly more effective than face to face CBT in reducing depression. MBB significant effective compared to TAU.
Mitchell, 2012	Depressive disorders (SCID)	Antenatal/ Prenatal	Yoga (N=12)	Psychoeducation (N=12)	The yoga versus control group showed greater decreases on the depressed affect and somatic/ vegetative subscales and the summary score of the Center for Epidemiological Studies Depression Scale.
Ormsby, 2020, 32658830	Depressive disorders (EPDS ≥ 13)	Antenatal/ Prenatal	Acupuncture (N = 19), Progressive Muscle Relaxation (PMR) (N=19)	TAU (N= 19)	There were significantly lower depression scores in the acupuncture group vs TAU and PMR respectively (p = <0.001). Lower acupuncture score for stress (p = 0.006), and psychological distress (p <0.001) when compared to PMR and TAU.
Pan, 2023, 37525110	Depressive, anxiety and stress disorder	Antenatal/ Prenatal	Mindfulness (N=51)	Control (N=51)	Prenatal mindfulness intervention group experienced reduced prenatal stress, anxiety,

Study	Mental Health Condition (Inclusion Criteria)	Perinatal Period	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
	(EPDS \geq 10, PRT, PSS-10)				and depression and reduced postnatal stress and depression. There was no significant difference between the groups in terms of the quality of mother-infant bonding.
Perkins, 2023, 37270855	Depressive disorder (EPDS >10)	Postnatal/ Postpartum	Online 6-week songwriting intervention (Songs from Home) (N=44)	Waitlist control (N=45)	Intervention group reported significantly lower scores postintervention and at follow-up for loneliness ($P < 0.001$) and postnatal depression ($p < 0.001$) and significantly higher scores at follow-up for social connectedness ($P < 0.001$).
Richter, 2012, 23078196	Stress, Anxiety and/ or Depression (MCID, BDI-IV >20, STAI >36, PDQ > 14)	Antenatal/ Prenatal	CBT + Psychoeducation (N=21)	TAU (N=40)	Subjects in the intervention exhibited a significant post-treatment change in morning cortisol (cortisol awakening response, CAR) in contrast to control subjects. Intervention participants showed a smaller CAR subsequent to the intervention, displaying a lessened stress reaction.
Rojas, 2007, 17993363	Depressive disorders (EPDS \geq 10)	Postpartum/ Postnatal	Psychoeducation + clinical monitoring (N=114)	TAU (N=116)	The crude mean EPDS score was lower for the multicomponent intervention group than for the usual care group at 3 months. Although these differences between groups decreased by 6 months, EPDS score remained better in multicomponent intervention group than in usual care group. The decrease in the number of women taking antidepressants after 3 months was greater in the intervention group than in the usual care group.
Stuart, 2023, 38074280	Depressive disorder (DSM-IV)	Postnatal/ Postpartum	Standard Interpersonal Psychotherapy (S-IPT) (N=69)	Clinician-Managed Interpersonal Psychotherapy (CM-IPT) (N=71)	Both CM-IPT and S-IPT were highly efficacious with similar outcomes by 12 weeks, but CM-IPT group utilized significantly fewer sessions. Both were superior to a waitlist control. Superiority comparisons at 12 months did not favor the CM-IPT condition.
Spinelli, 2003, 12611838	Depressive disorder (DSM-IV)	Antenatal/ Prenatal	Interpersonal Psychotherapy (IPT) (N=21)	Didactic parenting education program (N=17)	IPT group showed significant improvement compared to the parenting education control program on all three measures of mood (EPDS, BDI, the Hamilton Depression rating Scale) at termination. Recovery criteria were met in 60% of the women treated with IPT (CGI score of ≤ 2).

Study	Mental Health Condition (Inclusion Criteria)	Perinatal Period	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
Suchan, 2022, 36066958	Depression or Anxiety (EPDS ≥ 10 , GAD-7 ≥ 9)	Postpartum/ Postnatal	CBT + Psychoeducation (N=30)	TAU (N=33)	The ICBT group experienced larger improvements after treatment and at the 1-month follow-up on more measures than the TAU group, with medium between-group Cohen d effects on primary outcome measures for anxiety, PPD and depression, and on secondary outcome measures of overall distress, anxiety, and stress. Time-by-group interactions for proportional reductions between groups over time were only significant after treatment and at the 1-month follow-up for the primary anxiety measure ($p=.006$).
Van Horne, 2022, 34866254	Depressive disorders (EPDS 10-20)	Postpartum/ Postnatal	Problem solving therapy (N=72)	TAU (N=46)	All participating mothers had significant decreases in PPD symptoms. The change in PPD symptoms among those in the home visitation program was not significantly different from the change in the control condition, indicating that the home visitation program was as effective as psychiatric treatment in significantly reducing PPD symptoms. A high proportion of women in the home visitation program completed visits and demonstrated increased maternal self-efficacy.
Vigod, 2019, 31257092	Depressive disorders (DSM IV revised)	Antenatal/ Prenatal	Transcranial direct current stimulation (tDCS) (N=10)	Sham (N=10)	Views of treatment were positive with no serious adverse events. Post-treatment estimated marginal mean MADRS scores were lower for tDCS compared to sham ($p = 0.34$). At 4 weeks postpartum, higher remission rate in for tDCS compared to sham ($p = 0.04$).
Wisner, 2017, 28796940	Depressive disorders (SCID, EPDS ≥ 10)	Postpartum/ Postnatal	DCM (telephone-delivered) (N = 312)	EUC (N=316)	Mean depressive symptom and function scores significantly improved (by greater than 50%) in both groups of women but did not differ by DCM versus EUC assignment. Health services use was similar in women randomly assigned to DCM compared to EUC. Women with childhood sexual abuse responded significantly more favorably to DCM on depression and functional measures (all P values $< .02$).

Abbreviations: BDI = Beck Depression Inventory, BAI = the Beck Anxiety Inventory, CBT=cognitive behavioral therapy, CES-D=Center for Epidemiological Studies Depression Scale, DCM= depression care management, EPDS = Edinburgh Postnatal Depression Scale, EUC=enhanced usual care, GAD= Generalized Anxiety Disorder, HAM-D= Hamilton

Depression Rating Scale, IPT = Interpersonal therapy, MCID=Munich-Composite International Diagnostic Interview, MINI= Mini-Neuropsychiatric Interview, PPD= postpartum depression, SCID= The Structured Clinical Interview for DSM-5, STAT= State-Trait Anxiety Inventory, TAU = treatment as usual, NR not reported

Table C-2. KQ 2: Evidence map

Study	Population (Disorder)	Population (Perinatal Period)	Intervention Arm (N)	Comparator Arm (N)	Primary Findings
Milgrom, 2015, 25586754	Depression and Anxiety (DSM IV revised, EPDS)	Postpartum/ Postnatal	CBT (N=14)	SSRI (N=15), CBT+SSRI (N=16)	CBT monotherapy was found to be superior to both SSRI monotherapy and CBT+SSRI combination therapy after 12 weeks.
Sharp, 2010, 20860888	Depressive disorders (ICD-9, CIS-R, EPDS ≥13)	Postpartum/ Postnatal	Antidepressant (SSRI recommended) (N=129)	Non-directive counseling (N=125)	There was no statistically significant difference in depression symptoms at the end of treatment between the antidepressant and counseling groups.

Abbreviations: CBT=cognitive behavioral therapy, CES-D=Center for Epidemiological Studies Depression Scale, EPDS = Edinburgh Postnatal Depression Scale, SSRI= selective serotonin reuptake inhibitors, CIS-R = clinical interview schedule, ICD-9 = international classification of diseases

Table C-3. Design details

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Alhusen, 2021, 32409986	United States	NR	Reported (No COI)	Age: ≥16, EPDS (Full) >12, <12 weeks gestation at the time of enrollment, English-speaking	Depressive disorders	Antenatal/ Prenatal	2	60
Amani, 2021, 34758210	Canada	Non-Industry	Reported (No COI)	Age: ≥18, had an infant < 12 months of age, EPDS (Full) ≥10, fluent in English, free of bipolar, psychotic, or current substance use disorders per the Mini-International Neuropsychiatric Interview (MINI).	Depressive disorders	Postpartum/ Postnatal	2	73
Ammerman, 2013, 23768664	United States	Non-Industry	NR	Age: ≥16, Structured diagnostic criteria/diagnostic tool: SCID, EPDS (Full) ≥11.	Depressive disorders	Postpartum/ Postnatal	2	93
Armstrong, 2003, 12956024	Australia	NR	NR	EPDS (Full) ≥12, Child aged between 6 wks to 12months. Able to complete aerobic exercise according to Physical Activity Readiness-Questionnaire.	Depressive disorders	Postpartum/ Postnatal	2	20
Bais, 2020, 33115894	Netherlands	Non-Industry	Reported (yes COI)	Age: 18–45, Structured diagnostic criteria/diagnostic tool: DSM V SCID, 12–32 weeks pregnant (as confirmed by ultrasound)	Depressive disorders	Antenatal/ Prenatal	2	67
Bittner, 2014, 25062520	Germany	Non-Industry	Reported (No COI)	Age: >18 yr, Structured diagnostic criteria/diagnostic tool: Munich-Composite International Diagnostic Interview, screening results of at least 1 questionnaire (PDQ >14 and/or STAI >36 and/or BDI-V >20), capable of reading German.	Depression or Anxiety	Antenatal/ Prenatal	2	118
Broberg, 2021, 32862425	Denmark	Non-Industry	Reported (No COI)	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM V, Danish speaking; singleton pregnancy;	Depressive disorders	Antenatal/ Prenatal	2	282

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Burger, 2020, 31806071	Netherlands	Non-Industry	NR	Structured diagnostic criteria/diagnostic tool: DSM IV revised SCID, EPDS (Full) ≥ 12 , STAI ≥ 42	Depression or Anxiety	Antenatal/Prenatal	2	282
Burns, 2013, 23339584	United Kingdom	Non-Industry	Reported (No COI)	Age: >16 , Structured diagnostic criteria/diagnostic tool: CIS-R, were between 8 and 18 weeks pregnant and who screened positive on a 3-question depression screen	Depressive disorders	Antenatal/Prenatal	2	36
Buttner, 2015, 25886805	United States	NR	Reported (No COI)	Age: 18-45, Structured diagnostic criteria/diagnostic tool: DSM-IV Axis-I Disorders (SCID-I), HAM-D ₁₇ ≥ 12 , PHQ-9 ≥ 10 , ≥ 6 weeks PP if delivery was either complicated and/or involved a cesarean section residence within a 30-mile radius of the yoga studios.	Depressive disorders	Postpartum/Postnatal	2	57
Canfield, 2023, 37853333	United States	Non-industry	Reported (No COI)	Structured diagnostic criteria/diagnostic tool: GAD-7 score ≥ 10 or PHQ-9 score ≥ 10 . Cohabiting with current partner, living in Missouri, and with internet access.	Depressive and/or anxiety disorders	Antenatal/Prenatal	2	30
Challacombe, 2017, 28137316	United Kingdom	Non-Industry	Reported (No COI)	Structured diagnostic criteria/diagnostic tool: DSM IV revised SCID	Obsessive-compulsive disorder	Postpartum/Postnatal	2	34
Chiorino, 2020, 31805778	Italy	Non-Industry	Reported (No COI)	Age: 18, score 24 on the (IES-R), having experienced a traumatic childbirth in the previous hours or at 3 most three days before (both objective and subjective traumatic childbirth-related experiences, fluent Italian language; legal capacity to consent to the treatment.	Post-traumatic stress disorder	Postpartum/Postnatal	2	37

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Cho, 2008, 18729297	South Korea	NR	NR	Structured diagnostic criteria/diagnostic tool: DSM IV revised SCID-IV-I, BDI >16, pregnant, consented to participate	Depressive disorders	Antenatal/ Prenatal	2	27
Chung, 2012, 22840621	Hong Kong	Non-Industry	Reported (No COI)	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM IV revised, EPDS (Full) ≥12, HDRS ₁₇ 12-19, ethnic Chinese and permanent residents in Hong Kong; within 6 mo of giving birth.	Depressive disorders	Postpartum/ Postnatal	2	20
Cooper, 2003, 12724244	United Kingdom	Non-Industry	Reported (No COI)	EPDS (Full) ≥12, primiparous, living within a 15-mile radius of the maternity hospital and with English as their first language	Depressive disorders	Postpartum/ Postnatal	4	190
Da Costa, 2009, 19728220	Canada	Non-Industry	NR	In the PP period (4–38 weeks), EPDS (Full) ≥10, English/French comprehension; no substance abuse; not currently in exercise program; no obstetrical or concomitant diseases precluding participation in exercise	Depressive disorders	Postpartum/ Postnatal	2	88
Daley, 2008, 18399022	United Kingdom	Non-Industry	Reported (No COI)	Age ≥ 16, EPDS (Full) > 12, whose youngest child < 12 months' old.	Depressive disorders	Postpartum/ Postnatal	2	38
Daley, 2015, 25804297	United Kingdom	Non-Industry	Reported (No COI)	Age: ≥ 18, Structured diagnostic criteria/diagnostic tool: ICD-10 (WHO), EPDS ^a (EPDS2 ≥13) and clinical diagnostic interview (CIS-R), within 6 mo of given birth.	Depressive disorders	Postpartum/ Postnatal	2	94

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Danaher, 2023, 36174746	United States	Non-Industry	Reported (No COI)	Age ≥ 18 , EPDS (Full) > 12 , pregnant or <1 year PP, no active suicidal ideation, access to broadband internet via desktop/laptop, tablet, or smartphone, and English language proficiency.	Depressive disorders	Perinatal/ Peripartum	2	191
Dennis, 2020, 32029010	Canada	Non-Industry	Reported (No COI)	Age: >18 , Structured diagnostic criteria/diagnostic tool: SCID, EPDS (Full) >12 , English-speaking; between 2- and 24-weeks PP, and discharged home from hospital with their infant.	Depressive disorders	Postpartum/ Postnatal	2	241
Dimidjian, 2017, 28045285	United States	Non-Industry	Reported (yes COI)	Age: ≥ 18 , PHQ-9 ^b ≥ 10 , English speaker, receiving care at one of the participating sites, no known diagnosis of bipolar disorder, psychotic disorder, active substance dependence, or immediate risk of self-harm or need for hospitalization	Depressive disorders	Antenatal/ Prenatal	2	163
Donmez, 2022, 35339911	Turkey	NR	Reported (No COI)	Age: 18–45, Structured diagnostic criteria/diagnostic tool: DSM V, EPDS (Full) ≥ 12 , ability to read, understand, and sign the informed consent form and understand study procedures, pregnant or in the first year PP.	Depressive disorders	Antenatal/ Prenatal Postpartum/ Postnatal	2	30
Field, 2013, 23337557	United States	Non-Industry	Reported (No COI)	Age < 40 , Structured diagnostic criteria/diagnostic tool: DSM IV revised SCID, being pregnant with one child; an uncomplicated pregnancy with no medical illness; not using drugs (i.e., prescribed or illicit).	Depression and Anxiety	Antenatal/ Prenatal	2	92

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Forsell, 2017, 28628768	Sweden	Non-Industry	Reported (No COI)	Age: ≥18, gestational week 11-28. Structured diagnostic criteria/ diagnostic tool: SCID-I, MADRS-S 15-35, only women with no or a low risk of suicide as indicated by a score of 4 or less on item 9 on MADRS-S and the clinician's assessment during the semi-structured telephone interview. able to use the internet for the ICBT	Depressive disorders	Antenatal/ Prenatal	2	42
Forsyth, 2017, 28278021	United Kingdom	NR	NR	Structured diagnostic criteria/diagnostic tool: DSM-IV SCID, EPDS (Full) ≥12 at women routine visit 6 weeks' PP.	Depressive disorders	Postpartum/ Postnatal	2	22
Gamble, 2005, 15725200	Australia	Non-Industry	NR	Age: >18, 3rd trimester; live birth expected. Structured diagnostic criteria/diagnostic tool: criterion A of DSM-IV-TR.	Post-traumatic stress disorder	Postpartum/ Postnatal	2	103
Green, 2020, 31957479	Canada	Non-Industry	Reported (No COI)	Age: 18–45, Structured diagnostic criteria/diagnostic tool: DSM IV, for principle anxiety with/no depression using DSM-5 no psychotropic medication or no change in dose and type for a minimum of 6 wks prior to baseline assessment; no changes in psychotropic medication during 6-week CBGT or 6-week waitlist; no concurrent psychological treatment; fluent in English, pregnant or within the first 6mo PP.	Depression and Anxiety	Antenatal/ Prenatal Postpartum/ Postnatal	2	86

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Grote, 2009, 19252043	United States	Non-Industry	Reported (No COI)	Age: ≥ 18 . EPDS (Full) >12 , range (0-30), 10 to 32 wks gestation, English speaking, access to a telephone, and living in the Pittsburgh region	Depressive disorders	Antenatal/ Prenatal	2	53
Hankin, 2023, 37074698	United States	Non-industry	Reported (Yes COI)	Age: 18 to 45 years, Structured diagnostic criteria/diagnostic tool: EPDS score ≥ 10 , DSM-5 [SCID-5], English speaking, 25 weeks' gestational age or less, singleton pregnancy	Depressive disorders	Antenatal/ Prenatal	2	234
Hayden, 2012, 22526914	United States	Non-Industry	Reported (No COI)	Age: 15-44, Structured diagnostic criteria/diagnostic tool: DSM-IV, DIS, preexisting diabetes (type 1 or type 2 or gestational) requiring insulin during pregnancy	Depressive disorders	Antenatal/ Prenatal	2	34
Honey, 2002, 12437794	United Kingdom	Non-Industry	NR	EPDS (Full) >12 , <12 mo PP	Depressive disorders	Postpartum/ Postnatal	2	45
Huh, 2023, 37498661	Canada	NR	NR	Age: 18 or older. Structured diagnostic criteria/diagnostic tool: EPDS score ≥ 10 , and infant under the age of 12 months.	Depressive disorders	Postpartum/ Postnatal	2	136
Husain, 2023, 37413896	United Kingdom	Non-Industry	Reported (yes COI)	Age ≥ 16 , Structured diagnostic criteria/diagnostic tool: ICD-10, living with their babies, having a child up to 12 months of age, British women of South Asian origin as defined by UK Office of - National Statistics,	Depressive disorders	Postpartum/ Postnatal	2	83

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Lenze, 2017, 28038377	United States	NR	NR	Age: ≥ 18 . Structured diagnostic criteria/diagnostic tool: DSM IV revised SCID, EPDS (Full) ≥ 10 . Pregnant between 12–30 wks gestation, singleton pregnancies.	Depressive disorders	Antenatal/ Prenatal	2	42
Leung, 2016, 26908335	Hong Kong	Non-Industry	NR	Age ≥ 18 . Structured diagnostic criteria/diagnostic tool: DSM IV revised, EPDS (Full) ≥ 10 , HADS (anxiety subscale) HADS (depression subscale), Hong Kong Chinese PP women, at 6 to 8 weeks after delivery, living with their husband,	Depressive disorders	Postpartum/ Postnatal	2	164
Loughnan, 2019, 30266030	Australia	Non-Industry	Reported (No COI)	Age > 18, completed brief online screening questionnaire, Australian resident; had computer and internet access; between 13 and 30 weeks pregnant.	Depression and Anxiety	Antenatal/ Prenatal	2	87
Loughnan, 2019, 30877878	Australia	Non-Industry	Reported (No COI)	Age > 18, GAD-7 and/or PHQ-9 ≥ 10 , within 12 months PP, Australian resident; computer and internet access;	Depression and Anxiety	Postpartum/ Postnatal	2	131
Madigan, 2015, 25703488	Canada	Non-Industry	NR	Age: 12-18 . Structured diagnostic criteria/diagnostic tool: Adult Attachment Interview (AAI) criteria (for an unresolved state of mind) or CPTSDI, having a score that fell above the clinical cutoff for dissociation;12-23 weeks of pregnancy, planning to keep the baby, fluent in English	Post-traumatic stress disorder	Antenatal/ Prenatal	2	43

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Manber, 2004, 15546651	United States	Non-Industry	NR	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM IV revised, HRSD ₁₇ ≥14, 11-28wk gestation; receiving prenatal care in the community.	Depressive disorders	Antenatal/ Prenatal	3	61
Manber, 2010, 20177281	United States	Non-Industry	Reported (No COI)	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM-IV-TR revised, HADS ₁₇ ≥14, 12 and 30wk gestation	Depressive disorders	Antenatal/ Prenatal	3	150
Mennen, 2021, 33221606	United States	Non-Industry	Reported (No COI)	Structured diagnostic criteria/diagnostic tool: CES-D >8	Depressive disorders	Postpartum/ Postnatal	2	119
Merza, 2023, 37649448	Canada	Non-industry	Reported (No COI)	Age: 18 or older. Structured diagnostic criteria/diagnostic tool: EPDS score ≥10, and infant under the age of 12 months.	Depressive disorders	Postpartum/ Postnatal	2	183
Milgrom, 2005, 16368032	Australia	Non-Industry	NR	Structured diagnostic criteria/ diagnostic tool: DSM IV revised, EPDS (Full), 37–42wk pregnancy; infant BW 2.5 kg and above, no congenital abnormality; no major health problem, and no concurrent major psychiatric disorder.	Depressive disorders	Postpartum/ Postnatal	4	192
Milgrom, 2011, 21615968	Australia	Non-Industry	Reported (No COI)	Age ≥18, EPDS ≥ 13, women with infant aged 6 weeks to 4 months.	Depressive disorders	Postpartum/ Postnatal	3	68
Milgrom, 2015, 25709044	Australia	Non-Industry	Reported (No COI)	Structured diagnostic criteria/diagnostic tool: DSM-IV, EPDS ≥ 13 (referred to interview), <30wk pregnancy	Depressive disorders	Antenatal/ Prenatal	2	54
Milgrom, 2016, 26952645	Australia	Non-Industry	Reported (No COI)	Age ≥18, Structured diagnostic criteria/diagnostic tool: DSM-IV SCID, EPDS (Full) 11-23 (screening criteria) ^c	Depressive disorders	Postpartum/ Postnatal	2	43

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Mulcahy, 2010, 19697094	Australia	Non-Industry	NR	Structured diagnostic criteria/ diagnostic tool: DSM IV revised, an infant aged ≤12 months	Depressive disorders	Postpartum/ Postnatal	2	57
Ngai, 2015, 26278623	Hong Kong	Non-Industry	Reported (No COI)	Age ≥18, EPDS (Full) ≥ 10, married, primiparous, Hong Kong residents, able to speak and read Chinese, giving birth to a single full-term healthy baby ^d	Depressive disorders	Postpartum/ Postnatal	2	397
Nieminen, 2016, 27152849	Sweden	Non-Industry	Reported (No COI)	Age: ≥18, Structured diagnostic criteria/diagnostic tool: MINI, TES sum score ≥30; having access to a computer and internet, able to read and write Swedish, not pregnant, not having problems requiring urgent care, not currently engaged in psychotherapy care, minimum of three months of traumatic delivery	Post-traumatic stress disorder	Postpartum/ Postnatal	2	56
O'Hara, 2000, 11074869	United States	Non-Industry	NR	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM IV revised (SCID), HAM-D ₁₇ ≥12, completed (IDD), were married or living with a partner for at least 6 months.	Depressive disorders	Postpartum/ Postnatal	2	120
O'Mahen, 2013, 23319454	United Kingdom	Non-Industry	NR	Age: ≥18, Structured diagnostic criteria/diagnostic tool: DSM-IV, EPDS (Full) ≥12, ≥24wks pregnant, no previous treatment for depression	Depressive disorders	Perinatal/ Peripartum	2	55
O'Mahen, 2013, 23602514	United Kingdom	Non-Industry	Reported (No COI)	Age: ≥18, EPDS (Full) >12, birth within 12 months	Depressive disorders	Postpartum/ Postnatal	2	910

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
O'Mahen, 2014, 24148703	United Kingdom	Non-Industry	Reported (No COI)	Age: >18, Structured diagnostic criteria/diagnostic tool: ICD-10, EPDS (Full) >12, live birth within year; no substance abuse or psychosis; speaking English.	Depressive disorders	Postpartum/ Postnatal	2	83
O'Mahen, 2022, 35177019	United Kingdom	Non-industry	Reported (Yes COI)	Age: 18 or older. Structured diagnostic criteria/diagnostic tool: GAD-7 score ≥ 7 .	Anxiety disorder	Antenatal/ Prenatal	2	114
Okatsau, 2023, 37163508	Japan	Non-Industry	Reported (No COI)	Age: 20 or older. Structured diagnostic criteria/diagnostic tool: 5 to 14 points on the GAD-7, more than 22 weeks pregnant, and able to speak, read and write in Japanese	Anxiety disorder	Antenatal/ Prenatal	2	63
Pearson, 2013, 22884235	United Kingdom	Non-Industry	Reported (No COI)	Age: >16, Structured diagnostic criteria/diagnostic tool: ICD-10 CIS-R, EPDS, 8-18wks pregnant.	Depressive disorders	Antenatal/ Prenatal	2	24
Prendergast, 2001,	Australia	Non-Industry	NR	Structured diagnostic criteria/diagnostic tool: DSM IV revised, EPDS (Full) >12	Depressive disorders	Postpartum/ Postnatal	2	37
Pugh, 2016, 26930488	Canada	Non-Industry	Reported (No COI)	Age: ≥ 18 , Structured diagnostic criteria/diagnostic tool: MINI, EPDS (Full) ≥ 10 , a birth within past year; Saskatchewan resident; not receiving concurrent psychotherapy; if medicated, stable dose for >1mo; no past or present psychotic mental illness, computer and Internet access,	Depressive disorders	Postpartum/ Postnatal	2	50

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Segre, 2015, 25486371	United States	Non-Industry	NR	Age: ≥14, Structured diagnostic criteria/diagnostic tool: DSM IV revised, Nonpatient Edition (SCID-I/NP), EPDS (Full) ≥12, were English or Spanish speaking, were not currently receiving counseling services although medication management was permitted	Depressive disorders	Antenatal/ Prenatal Postpartum/ Postnatal	2	66
Shaw, 2014, 25049338	United States	Non-Industry	Reported (No COI)	Age: >18, infants aged 25 to 34wks ^e , score > the clinical cutoff on 1 of 3 screening instruments administered at baseline: BAI, SASRQ, BDI-II (BAI ≥16 SASRQ ≥3, BDI-II ≥20), English- or Spanish-speaking.	PTSD, anxiety, depression	Postpartum/ Postnatal	2	105
Stein, 2018, 29413138	United Kingdom	Non-Industry	Reported (No COI)	Age: ≥18. Structured diagnostic criteria/diagnostic tool: DSM IV revised, full diagnostic criteria, infant born at 35 or more weeks, BW ≥2000g, 4.5-9mo old, and with no serious complications.	Depressive disorders	Postpartum/ Postnatal	2	144
Toth, 2013, 24229549	United States	Non-Industry	NR	Age: 18-40, Structured diagnostic criteria/diagnostic tool: DSM IV revised, BDI-II ≥19, CES-D >16, reside at or below the federal poverty level, with a 12-month-old infant.	Depressive disorders	Postpartum/ Postnatal	2	128
Trevillion, 2020, 31634678	United Kingdom	Non-Industry	Reported (yes COI)	Age: ≥16, Structured diagnostic criteria/diagnostic tool: DSM IV revised, pregnant (not exceeding 26wks gestation)	Depressive disorders	Antenatal/ Prenatal	2	53

Study, Year, PMID	Country	Funding	COI	Eligibility Criteria	Disorder	Perinatal Period	Number of Arms	Total N Randomized
Upshur, 2016, 27480668	United States	Non-Industry	NR	Age: 18, Primary care PTSD Screen ≥ 2 , initiated prenatal care before 27 weeks gestation, spoke English, Spanish, Vietnamese, or Portuguese.	Post-traumatic stress disorder	Antenatal/ Prenatal	2	149
Van Lieshout, 2021, 34495285	Canada	Non-Industry	Reported (No COI)	Age: ≥ 18 , EPDS (Full) ≥ 10 , infant younger than 12mo	Depressive disorders	Postpartum/ Postnatal	2	403
Van Lieshout, 2022, 35060398	Canada	Non-Industry	Reported (No COI)	Age: ≥ 18 , EPDS (Full) ≥ 10 , had an infant < 12 mo	Depressive disorders	Postpartum/ Postnatal	2	141
Van Lieshout, 2023, 36878891	Canada	Non-Industry	Reported (No COI)	Age: ≥ 18 or older, EPDS (Full) ≥ 10 , infant younger than 12mo	Depressive disorders	Postpartum/ Postnatal	2	461
Vigod, 2021, 33949762	Canada	Non-Industry	Reported (yes COI)	Age: ≥ 18 , EPDS (Full) ≥ 10 , an infant between 0 and 12 months old, Reside in Ontario.	Depressive disorders	Postpartum/ Postnatal	2	98
Wiklund, 2010, 20636249	Sweden	Industry	Reported (No COI)	EPDS (Full) ≥ 12 , Women with healthy newborns, who had an instrumental delivery or an emergency cesarean section, were therefore chosen as the study group.	Depressive disorders	Postpartum/ Postnatal	2	67
Wirz-Justice, 2011, 21535997	Switzerland	Non-Industry	Reported (yes COI)	Age: 18-45. Structured diagnostic criteria/diagnostic tool: DSM IV revised, EPDS (Full) ≥ 10 , SIGH-ADS ≥ 20 . Pregnancy 4 through 32wks gestation, medically healthy, with normal ocular function.	Depressive disorders	Antenatal/ Prenatal	2	46
Wozney, 2017, 28593360	Canada	Non-Industry	Reported (yes COI)	Age: 19-45, Structured diagnostic criteria/diagnostic tool: DSM-IV-TR Axis I Disorders SCID-I, 1-12 mo PP, live in Nova Scotia, access to a telephone, if medicated, should be stable for the 4 weeks prior to study	Depressive disorders	Postpartum/ Postnatal	2	62

^aWomen who scored on first EPDS1 then completed a second EPDS2 2 weeks later by telephone to rule out the possibility of transient depression. Women who scored 13+ on the EPDS-2 then completed the Clinical Interview Schedule-Revised (CIS-R). ^bExpanded from the initial plan to require ≥ 15 given clinical guidelines in the delivery settings that recommended additional screening and intervention for such patients), ^cAnother screening criteria: Australian residency, Internet access with regular email use, < than 1 year PP, d(gestation between 37 and 41 weeks; body weight >2.5 kg; APGAR score at 5 min >7), eweighing 600 g and born at or transferred to NICUs within the first week of delivery,

Abbreviation; MINI: Mini-Neuropsychiatric Interview, PDQ= Prenatal Distress Questionnaire, STAI = State-Trait Anxiety Inventory, BDI = Beck Depression Inventory, PP = post-partum, IES-R = Impact of Event Scale-Revised, HDRS17 = 17-item Hamilton Rating Scale for Depression, MDD = Major depressive disorder, MADRS-S = Montgomery-Asberg Depression Rating Scale- Self report version, PHQ-9; Patient health questionnaire, BW = birth-weight, TES = Traumatic Events Scale, IDD = Inventory to Diagnose Depression, BAI = the Beck Anxiety Inventory, SASRQ = Stanford Acute Stress Reaction Questionnaire, SIGH-ADS = Structured Interview Guide for the Hamilton Depression Rating Scale (HAMD) with Atypical Depression Supplement, DSM-IV-TR = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised, DIS = National Institute of Mental Health Diagnostic Interview Schedule

Table C-4. Baseline characteristics

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Alhusen, 2021, 32409986	CBT (30) TAU (30)	24.5 (5.5)	White or Caucasian: 10 Black or African: 90	7th-9th grade: 20. 10th-12th grade: 33. HS grad/GED: 38 Some college/college degree: 6	Unemployed: 76 Employed, part-time: 7. Employed, full-time: 17	NR
Amani, 2021, 34758210	CBT (Peer-delivered group CBT) (37) TAU (Waitlist group) (36)	31.6 (4.7)	White or Caucasian: 94.3 Other: 5.6	Education (y): mean (SD) 14.6 (1.6)	NR	Married/common-law: 92 Single: 8
Ammerman, 2013, 23768664	CBT (47) TAU (46)	22 (4.6)	White or Caucasian: 62.3 Black or African: 32.4 Bi-racial: 2.2 Other: 4.2	Educational (years) mean (SD) 11.5 (1.5)	NR	Married: 12.9 Single never married & separated: 87.1
Armstrong, 2003, 12956024	Exercise (10) TAU (10)	The majority ^a were between 21-30	NR	NR	The majority were ^a homemakers	Married/de facto relationship 100
Bais, 2020, 33115894	Bright light therapy (33) Dim light therapy (Dim red-light therapy) (34)	31.9 (4.85)	Dutch: 79.1 Other: 20.9	Elementary or (pre-) vocational education: 35.8, Higher professional education: 28.4, (Pre-)academic education: 35.9	NR	Married or cohabiting: 97.1 Single: 0.5
Bittner, 2014, 25062520	CBT (39) TAU (79)	29.6 (4.2)	NR	Ninth grade 0.95 Tenth grade 19.4 High school (12th grade) 84.7 Other 10	Unemployed 6.3 Employed 93.8	Married: 43.2

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Broberg, 2021, 32862425	Exercise (143) TAU (139)	29.5 (3.9)	NR	Advanced degree: 51.8 3-4 y higher education: 30.9 1-2 y higher education: 5 Skilled workers: 4.3 Compulsory education: 7.4	Employed: 65.2 Unemployed: 12.4 Student: 18.8 Other: 0.04	Living with partner: 95.4
Burger, 2020, 31806071	CBT (140) TAU (142)	32.8 (4.6)	White or Caucasian: NR Black or African (Black and minority ethnic) 4.1 Asian: NR Hispanic or Latinx: NR	NR	NR	Marital status single: 8.1
Burns, 2013, 23339584	CBT (CBT + TAU) (18) TAU (18)	29.2 (5.6) range 20-41	White or Caucasian: 83.3 Other races: NR	'O' level or equivalent and above) 86.1	Working (full or part time) 58.4	Married/ living as married 63.9
Buttner, 2015, 25886805	Yoga/ Tachi (28) TAU (29)	31.2 (5.0)	White or Caucasian: 89.5 Non-Hispanic: 93 Black or African: NR Asian: NR Hispanic or Latinx: NR Other: NR	Mean years of education 16.8 (2.27)	Employed: 66	Married: 79
Canfield, 2023, 37853333	CBT (15) TAU (15)	31.0 (7.80)	White or Caucasian: 76.5 Black: 23.5	Completed college: 55	Employed: 88	With current partner: 98.5
Challacombe, 2017, 28137316	CBT (17) TAU (17)	32.6 (NR)	White or Caucasian: 85 Other races: NR	to degree level or above 67.5	NR	With partner 99

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Chiorino, 2020, 31805778	EMDR (Eye Movement Desensitization and Reprocessing) (19) TAU (18)	34.4 (5.6)	NR	Low secondary school 10.8 High secondary school 29.7 Degree 59.5	Unemployed 18.9 Employed 62.2 other 18.9	Married / Cohabiting: 97.3 Single 2.7
Cho, 2008, 18729297	CBT (12) TAU (15)	29.6 (3.4)	NR	High school 54.5 College 40.9 Graduate School 4.5	Housewife 63.6 Working wife 36.4	NR
Chung, 2012, 22840621	Acupuncture (10) Sham Acupuncture (10)	34.9 (3.6)	Asian: 100% Other races: 0.0	Full-time education in year, mean (SD): 12.0 (3.7)	Employed: 85	Married/cohabiting: 80 Single/Divorced/widowed: 20
Cooper, 2003, 12724244	Counseling (48) CBT (42) Psychodynamic (48) TAU (Routine primary care) (52)	27.7 (5.4) Range: 17-42	NR	None/CSE/'O' level/GSCE 45.3 'A' level/further qualification 31 Degree/higher degree 23.5	NR	Married/co-habiting 88 Single/divorced/widowed 12
Da Costa, 2009, 19728220	Exercise (46) TAU (42)	33.5 (4.1)	White or Caucasian: 78.3 Other races: NR	Education (years) Mean (SD) 15.6 (2.2)	NR	NR
Daley, 2008, 18399022	Exercise (47) TAU (47)	Range (%) 21-30: 52.6 31-40: 44.7 >40: 2.6	White or Caucasian: 73.7 Other races: NR	NR	Paid 68.4 Unemployed 10.5 Looking after family/home 15.8 Sick disabled 2.6	Married/with Partner: 76.3

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Daley, 2015, 25804297	Exercise (47) TAU (47)	30.5 (5.5)	White or Caucasian: 62.8 Black or African: 3.2 Black-Caribbean: Asian: 21.3 Mixed: 5.3 Hispanic or Latinx: NR Other: 6.4	NR	Paid 45 Self-employed 2 Unemployed 13 Student 3 Looking after home/family 35.5	Living with husband 88
Danaher, 2023, 36174746	CBT (96) TAU (95)	31.9 (5.2)	White or Caucasian: 67.4 Black or African: 8.0 Asian: 14.5 Hispanic or Latinx: 12.4 Other: 10.2	Less than high school 1.1 High school graduate 15.2 GED 1.6 Associate degree or Trade School 7.4 Bachelor's degree 33 Master's or other graduate degree 34.1 Doctoral or postgraduate degree 7.9	NR	Married or in long-term relationship: 94.2. Single: 5.8
Dennis, 2020, 32029010	IPT (120) TAU (121)	30.6 (6.0)	Canadian: 51.7 Other: 48.2	Elementary 7.8 High school 17 College 30.7 Undergraduate university 32.8 Graduate university 11.6	NR	Married/common-law marriage: 92.6
Dimidjian, 2017, 28045285	CBT (86) TAU (77)	28.8 (5.7)	White or Caucasian: 58.3 Black or African: 27.6 Asian: 4.3 Hispanic or Latinx: 15.3 Other: 9.82	< High school 7.4 High school 23.9 Some college 36.2 College 19.02 Graduate school 13.5	Employed full- or part-time 70.6	Married/ cohabiting: 69.9 Single never married and Divorced/ separated: 30.1

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Donmez, 2022, 35339911	Bright light therapy (15) placebo (15)	28.87 (5.35)	NR	Primary School 43.3 High School 33.3 University 23.3	NR	Married: 96.7 Divorced: 3.3
Field, 2013, 23337557	Yoga/ Tachi (46) TAU (46)	25.2 (5.2)	White or Caucasian: 2.5 Black or African: 39 Asian: NR Hispanic or Latinx: 58.5	Mean (SD) 4.1 (2.7)	NR	Married: 17.5 Single: 35 Boyfriend 47.5
Forsell, 2017, 28628768	CBT (Internet delivered CBT) (22) TAU ^b (20)	31 (4.5)	NR	High school: 27 University: 73	Working or self-employed: 78.5 Sick leave: 17 Unemployed: 5 Maternity leave: 12	In a committed relationship: 98
Forsyth, 2017, 28278021	Exercise (11) TAU (11)	26.0 (5.3)	NR	University undergraduate degree: 9.1 Left school at 18: 31.8. Left school at 16: 59.1	Full time 59.1 Part-time 4.5 Unemployed 40	Married/living with partner: 77.3. Never married: 22.7
Gamble, 2005, 15725200	Counseling (Not directive) (50) TAU (53)	28 (6.04)	White or Caucasian: 93.2 Black or African: NR Asian: 1.0 Hispanic or Latinx: NR Other: 2.9	Secondary education 60.2 Tertiary study 35.9 Higher degree 3.9	NR	Married/de facto: 85.4 Single/Separated/divorced : 14.6
Green, 2020, 31957479	CBT group format) (44) TAU (Waitlist) (42)	31.9 (3.6)	White or Caucasian: 90.7 Black or African: 1.2 Asian: 1.2 Hispanic or Latinx: 2.4 Other: 4.6	High school 9.3 Certificate/professional diploma 31.4 Bachelor's degree 37.3 Post-graduate degree (MA, PhD, MD) 22.1	NR	Married/common-law: 91.9 Single: 8.1

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Grote, 2009, 19252043	IPT (25) TAU (28)	24.5 (5.5)	White or Caucasian: 28 Black or African: 62.3 Asian: NR Hispanic or Latinx: 4 Other: 5.7	Less than high school 13, High school degree 26.4, GED 11 Vocational degree or some college 45.2, College or graduate degree 9	Full-time 15 Part-time 21 Unemployed 64	Married 7.5 Cohabiting 32 Divorced separated or widowed 11.5 Never married 49:
Hankin, 2023, 37074698	IPT (115) TAU (119)	29.9 (5.9)	Asian: 4.3% Black: 9.4% Hispanic: 18.4% Native Hawaiian/ Pacific Islander: 0.4% Non-Hispanic White: 43.2% Multiracial or multiethnic: 24.8%	<High school: 5.5% High school: 19.2% Some college: 29.9% College degree: 29.5% Graduate degree: 15.8%	NR	Cohabiting with partner: 74.4%
Hayden, 2012, 22526914	CBT (20) Counseling (14)	30.7 (5.0)	NR	NR	NR	NR
Honey, 2002, 12437794	CBT (23) TAU (22)	27.9 (5.52)	NR	NR	NR	married or cohabiting: 78
Huh, 2023, 37498661	CBT (71) TAU (65)	31.5 (4.85)	Non-white: 20.5	Mean years of education 14.85 (SD 1.75)	NR	Married/common-law: 91
Husain, 2023, 37413896	CPT (42) TAU (41)	30.3 (5.7)	British South Asian ^d : 100	NR	NR	NR

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Lenze, 2017, 28038377	IPT (21) TAU (21)	26.46 (5.9) Range 18-40	White or Caucasian: 16.7 Black or African: 78.6 Asian: 0.0 Hispanic or Latinx: 0.0 Other: 5	Some high school 26.2 High school diploma/GED 23.8 Some college or 2-year degree 38.1 4-year college/graduate degree 11.9	Employed 17 (40.5)	Married/Living in marriage-like relationship: 28.6 Never Married 64.3 Separated/Divorced 9.5:
Leung, 2016, 26908335	CBT (82) TAU (82)	31.2 (4.7)	Asian ^c 100	Secondary & below 59.5 Tertiary & above 40.2	Full time work 61.6 Housewife 23.8 Other 9.9	NR
Loughnan, 2019, 30877878	CBT (69) TAU (62)	32.56 (4.53)	NR	No qualification 1 School-level 12 Trade/certificate 14 Diploma 8 Undergraduate 48 Post-graduate 18	Full-time paid work/study 11 Part-time paid work/study 14 At home parent 38 Maternity leave 23 Other 15	In a relationship Married/de facto: 96 Single 3 Separated/Divorced: 1
Loughnan, 2019, 30266030	CBT (43) TAU (44)	31.61 (4.00)	NR	School Level 5 Trade/certificate/diploma 16 University undergraduate degree 60 University post-graduate degree 19	Full time paid work 52 Part-time paid work 31 Full-time student 3 Part-time student 4 At home parent 9 Unemployed 1	In a relationship/de factor or Married: 95 Separated or divorced 1 single: 4
Madigan, 2015, 25703488	CBT (21) TAU (22)	17.0 (0.9)	NR	Years of maternal education (it can be assumed) 10.1 (1.1)	NR	Married/in Relationship: 10.0 Single-Parent Status: 90.0

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Manber, 2004, 15546651	Acupuncture (20) Sham Acupuncture (21) Massage ^d (20)	33.3 (4.7)	Caucasians 75%	93% had at least some college education	NR	NR
Manber, 2010, 20177281	Acupuncture (Specific for Depression) (52) Acupuncture (Not Specific for Depression) (49) Prenatal Massage ^d (49)	32.9 (4.9)	White or Caucasian: 65.2 Black or African: 5.5 Asian: 8.9 Hispanic or Latinx: 17.9 Other: 20.3	High school 3.4 Some college 20.8 College 42.4 Graduate school 32.7	Work 61.2 Student 2.7 Unemployed/homemaker 36.1	NR
Mennen, 2021, 33221606	IPT (49) TAU (70)	32.7 (6.8)	White or Caucasian: 0.8 Black or African: 14.3 Asian: 0.8 Hispanic or Latinx: 80.7 Other: 3.4	Less than high school 38.7 High school diploma 27.7 Some college/trade school 26.1 College degree or higher 7.6	NR	NR
Merza, 2023, 37649448	CBT (92) TAU (91)	31.7 (4.8)	White or Caucasian: 78.9 Other: 21.1	Mean years of education: 15.1 (1.4)	NR	Married/common-law: 92.9 Single: 7.1

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Milgrom, 2005, 16368032	Individual CBT (46) Group Based counseling (47) Individual counseling (66) TAU (33)	29.7 (5.4)	NR	12 or more years of school 62.7 Higher education 30.5	NR	Living with a partner: 81.4
Milgrom, 2011, 21615968	CBT (Nurse led) (22) CBT (Psychologist led) (23) TAU (Routine GP management) (23)	31.5 (4.4)	NR	High school only 22.1 Degree or Higher 63.2	NR	Married/De Facto 86.8 No partner 10.3
Milgrom, 2015, 25709044	CBT (27) TAU (27)	NR	NR	High school only 20.4 Certificate level 16.7 Diploma level 13.0 University degree 35.2 Postgraduate 14.8	NR	Married/De facto 88.9 Separated/Single 11.1
Milgrom, 2016, 26952645	CBT (21) TAU (22)	31.6 (4.5)	NR	Did not finish school 2.3 High school only 11.6 Certificate level 16.3 Diploma level 20.9 Undergraduate degree 30.2 Postgraduate degree 18.6	NR	Married/Living with partner: 88.4. Single: 11.6

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Mulcahy, 2010, 19697094	IPT (29) TAU (28)	32.2 (3.4)	NR	University education 60.8	Home duties 79.9	Married: 97.9
Ngai, 2015, 26278623	CBT (197) TAU (200)	30.8 (4.1)	Asian ^e 100	Primary or below 0.8 Secondary 42.8 Tertiary/university or above 56.4	Unemployed 19.4 Employed 80.6	Married ^e 100
Nieminen, 2016, 27152849	CBT (28) TAU (28)	34.6 (4.8)	NR	University degree 80.4	Studying 7.1 Employed 67.9 Parental leave 17.9 Unemployed 3.6	Cohabiting/ married: 94.6
O'Hara, 2000, 11074869	IPT (60) TAU (60)	29.6 (4.7)	White or Caucasian: Almost all participants	Years of education, mean (SD) 14.7 (1.9)	Working: 63.3	Married or living with a partner for at least 6 months ^s 100
O'Mahen, 2013, 23319454	CBT (30) TAU (25)	27.01 (5.7) Range 18-43	White or Caucasian: 30.7 Black or African: 58.7 Asian: 7 Hispanic or Latinx: Other: 3.7	Below high school 23.7 High school 29.7 Some college 20.4 College graduate 15.7 Beyond college 10.7	Currently employed for pay 14.7	Partnered 67
O'Mahen, 2013, 23602514	CBT (462) TAU (448)	32.3 (5.2)	NR	None 1.3 Secondary 25.4 Post-16 27.4 First degree of Higher degree 44.1	Leave 65.9 Full or part-time employment 32.8 Student or volunteer 1	Married/cohabiting: 93.6 Divorced/separated/single: 2.7. Not in a relationship now 3.7
O'Mahen, 2014, 24148703	Behavioral Activation (41) TAU (42)	NR	White or Caucasian (British): 92.8 Black or African: 1.2 Asian: 1.2 Hispanic or Latinx NR Other: 2.4 Mixed (white/African/Caribbean) 2.4	None 1.2 Secondary. 18.0 Post-16 years 27.8 Undergraduate degree 30.2 Graduate degree 22.9	Homemaker/maternal leave/disability 80.5 Full- or part-time employment 10.8 Student or volunteer 8.5	Married/cohabiting: 91.6. Not in a relationship now: 8.4

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
O'Mahen, 2022, 35177019	CBT (57) TAU (57)	31.5 (5.09)	White or Caucasian: 63.2 Black: 3.5 Asian: 9.6	Some high school: 9.6 High school diploma/A level: 11.4 Technical college: 11.4 University degree: 30.7 (Post)Graduate degree: 29.8 Other/missing: 7.1	NR	NR
Okatsau, 2023, 37163508	CBT (33) TAU (30)	33.4 (4.50)	NR	High school: 14.3 Junior college/vocational school: 22.7 University/graduate school: 20.0	Full-time work: 60.2 Part-time work: 9.55 Self-employed: 1.5 Unemployed: 28.75	NR
Pearson, 2013, 22884235	CBT (12) TAU (12)	29.0 (5.7)	NR	"A" level or above: 58.3	NR	NR
Prendergast, 2001	CBT (17) TAU (20)	32.2	NR	Tertiary educated 75	NR	Married 92
Pugh, 2016, 26930488	CBT (24) TAU (23)	NR	White or Caucasian: 96 Other: 4	< Grade 12: 6.4 High School Diploma; GED 10.6 College/ Some University 19.1 Undergraduate Degree 46.8 Graduate Degree(s) 17.0	NR	Married/Common-Law 85.1 Engaged 2.1 Dating 2.1 Single 10.6
Segre, 2015, 25486371	Counseling (Listening visit) (41) TAU (25)	26.0 (5.8)	White or Caucasian: 33.9 Black or African: 32.3 Asian: NR Hispanic or Latinx: 40 Other (Multiracial): 8.5	Currently enrolled in school 16.9	Employed 33.5	Married/cohabiting: 47.3

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Shaw, 2014, 25049338	CBT (62) TAU (43)	32.2 (5.9)	White or Caucasian: 61.0 Black or African: NR Asian: NR Hispanic or Latinx: 28.6 Other: NR	less than college degree 36.2	NR	Married/ partner: 96.2. Single/divorced 3.8
Stein, 2018, 29413138	CBT (72) CBT (72)	32.0 (5.5)	White or Caucasian (British): 82.6 Other Ethnicity: 17.4	No qualifications 2.8 School level education 38.2 Certificate or diploma of higher education 11.1 University degree 48.0	NR	Living with father: 87.5
Toth, 2013, 24229549	IPT (99) TAU (29)	25.4 (5.4)	White or Caucasian: 38.3 Black or African: 59.4 Asian: NR Hispanic or Latinx: 21.1 Other: 2.3	High school: 57.8	NR	Married 11.7
Trevillion, 2020, 31634678	CBT (26) TAU (27)	Range < 25 9.4 Range 25-29 15.1 Range 30-39 68.0 Range 40 + 7.6	White or Caucasian: 66.04 Black or African: 26.24 Asian: 1.89 Hispanic or Latinx: NR Other/Mixed: 5.66	None/only school qualifications 15.09 Training/Higher Certificate/Diploma 26.42 Degree/Postgraduate 58.49	Working 83.02 Student 1.89 Unemployed 7.55 Homemaker 5.66 Not working due to illness/other 1.89	Married/ Cohabiting 67.92 Partner not cohabiting 15.09. Single: 16.98

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Upshur, 2016, 27480668	Psychoeducation (89) TAU (60)	27.1 (6.1)	White or Caucasian: 12.8 Black or African: 14.1 Asian: 66.4 Hispanic or Latinx: 8 Other: 8	Less than high school 41.6 High school diploma or GED 28.9 Some college or trade school 23.5 College degree 4.7 Master's degree 1.3	No. employed 34.2	Married 18.1 Living with partner: 13.4 Separated 4.0 Divorced 2.7 Never married 61.7
Van Lieshout, 2021, 34495285	CBT (202) TAU (201)	31.8 (4.4)	White or Caucasian: 72.2 Other races NR	Educational attainment by years, mean (SD) 16.8 (2.4)	NR	Married or common-law relationship: 91.3
Van Lieshout, 2022, 35060398	CBT (57) TAU (62)	30.9 (4.8)	NR	Educational by years, mean (SD) 18.0 (3.4)	NR	Married/common law) 93
Van Lieshout, 2023, 36878891	CBT (229) TAU (232)	31.95 (4.8)	White or Caucasian: 64.5 Black or African: 1.5 Asian: 14.5 Hispanic or Latinx: 4 Other: 17	Years of education 15.6 (2.1)	NR	Married/common law: 93
Vigod, 2021, 33949762	IPT (49) TAU (47)	33 (5.0)	NR	Completed university or college 79.2	NR	Married/cohabiting common law: 98.0
Wiklund, 2010, 20636249	CBT (33) TAU (34)	NR	NR	NR	NR	Married: 95.5
Wirz-Justice, 2011, 21535997	Bright light therapy (24) Placebo light therapy (22)	32.2 (5.1)	Eastern European 14.8	No of school years: 11.6 (3.6)	NR	NR

Study, Year, PMID	Study Arms (n)	Mean Age (A)	White/ Black/ Other %	Education %	Employment Status %	Relationship Status %
Wozney, 2017, 28593360	CBT (32) TAU (30)	29.0 (4.8)	NR	Less than high school 3 High school 25.8 Graduated college 27.4 Undergraduate degree 19.4 Graduate degree 24.2	NR	Married or cohabitating: 80.6. All other 19.5

^aNo numeric data reported, ^b(continuation of current maternity care for 10 weeks, followed by optional ICBT, or to be given ICBT immediately as an add-on to maternity care),

^cFrom eligibility criteria ^dData of massage group was not extracted, ^eFrom eligibility criteria and description of sample in discussion, ^fFrom eligibility criteria, ^gTherapist-Assisted Internet-Delivered Cognitive-Behavior Therapy,

Abbreviation; TAU = Treat as usual, including ((including waitlist/ control/ inactive group), IPT = Interpersonal therapy, NA = Not applicable

Table C-5. Summary of all study arms, KQs, and allocation to evidence map

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
Alhusen, 2021, 32409986	Depression	CBT	TAU	NA	NA	KQ1	No
Amani, 2021, 34758210	Depression	CBT	TAU	NA	NA	KQ1	No
Ammerman, 2013, 23768664	Depression	CBT (Note: Delivered during home visits)	TAU	NA	NA	KQ1	No
Armstrong, 2003, 12956024	Depression	Exercise	TAU	NA	NA	KQ1	No
Bais, 2020, 33115894	Depression	Bright light therapy	Placebo light therapy	NA	NA	KQ1	No
Bittner, 2014, 25062520	Depression	CBT	TAU	NA	NA	KQ1	No
Broberg, 2021, 32862425	Depression	Exercise	TAU	NA	NA	KQ1	No
Burger, 2020, 31806071	Depression	CBT	TAU	NA	NA	KQ1	No
Burns, 2013, 23339584	Depression	CBT	TAU	NA	NA	KQ1	No
Buttner, 2015, 25886805	Depression	Exercise (Note: Yoga)	TAU	NA	NA	KQ1	No
Canfield, 2023, 37853333	Depression/Anxiety	CBT	TAU	NA	NA	KQ1	No
Chabrol, 2002, 12214785	Depression/Anxiety	CBT + Psychoeducation + Supportive therapy + Psychodynamic therapy	TAU	NA	NA	KQ1	Yes
Challacombe, 2017, 28137316	OCD	CBT	TAU	NA	NA	KQ1	No
Challacombe, 2024, 37848088	PTSD, OCD, panic disorder or social anxiety disorder	CBT	CBT	NA	NA	KQ1	Yes
Chiorino, 2020, 31805778	PTSD	EMDR	TAU	NA	NA	KQ1	No
Cho, 2008, 18729297	Depression	CBT	TAU	NA	NA	KQ1	No
Chung, 2012, 22840621	Depression	Acupuncture (Note: Electroacupuncture)	Sham acupuncture	NA	NA	KQ1	No

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
Cluxton-Keller, 2023, 37921846	Depression	Family therapy	Problem-solving therapy	NA	NA	KQ1	No
Cooper, 2003, 12724244	Depression	CBT	TAU	Psychodynamic therapy	Non-directive counseling (Note: listening visits)	KQ1	No
Da Costa, 2009, 19728220	Depression	Exercise	TAU	NA	NA	KQ1	No
Daley, 2008, 18399022	Depression	Exercise	TAU	NA	NA	KQ1	No
Daley, 2015, 25804297	Depression	Exercise	TAU	NA	NA	KQ1	No
Danaher, 2023, 36174746	Depression	CBT	TAU	NA	NA	KQ1	No
Dennis, 2020, 32029010	Depression	IPT	TAU	NA	NA	KQ1	No
Dimidjian, 2017, 28045285	Depression	Behavioral Activation	TAU	NA	NA	KQ1	No
Donmez, 2022, 35339911	Depression	Bright light therapy	Placebo light therapy	NA	NA	KQ1	No
Evans, 2021, 34649534	Depression/Anxiety	IPT (Note: Interpersonal counseling)	CBT	NA	NA	KQ1	Yes
Fancourt, 2018, 29436333	Depression/Anxiety	Singing group	Play Group	TAU	NA	KQ1	Yes
Field, 2009, 19761951	Depression/Anxiety	IPT + Massage	IPT	NA	NA	KQ1	Yes
Field, 2013, 23337557	Depression and Anxiety	Exercise (Note: Yoga+Tai Chi)	TAU	NA	NA	KQ1	No
Field, 2013, 23727060	Depression/Anxiety	IPT	Peer support	NA	NA	KQ1	Yes
Field, 2013, 24138994	Depression/Anxiety	Exercise (Note: Yoga)	Peer support	NA	NA	KQ1	Yes
Forsell, 2017, 28628768	Depression	CBT	TAU	NA	NA	KQ1	No
Forsyth, 2017, 28278021	Depression	Exercise	TAU	NA	NA	KQ1	No
Gamble, 2005, 15725200	PTSD	Non-directive counseling	TAU	NA	NA	KQ1	No

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
Gjerdingen, 2013, 23799688	Depression/Anxiety	Doula support	Peer support	TAU	NA	KQ1	Yes
Green, 2020, 31957479	Depression and Anxiety	CBT	TAU	NA	NA	KQ1	No
Grote, 2009, 19252043	Depression	IPT (Note: Culturally adapted)	TAU (Note: Enhanced usual care)	NA	NA	KQ1	No
Hamilton, 2021, 32997871	Depression/Anxiety	Cognitive Analytic Therapy	TAU	NA	NA	KQ1	Yes
Hankin, 2023, 37074698	Depression	IPT	TAU	NA	NA	KQ1	No
Hayden, 2012, 22526914	Depression	CBT	Non-directive counseling	NA	NA	KQ1	No
Heller, 2020, 32202505	Depression/Anxiety	Problem solving therapy	TAU	NA	NA	KQ1	Yes
Honey, 2002, 12437794	Depression	CBT	TAU	NA	NA	KQ1	No
Horwitz, 2015, 25452159	Depression/Anxiety	CBT (Note: Trauma focused)	Psychoeducation	NA	NA	KQ1	Yes
Huh, 2023, 37498661	Depression	CBT	TAU	NA	NA	KQ1	No
Husain, 2023, 37413896	Depression	CBT (Note: Culturally adapted)	TAU	NA	NA	KQ1	No
Johnson, 2016, 27003141	Depression/Anxiety	IPT	Psychoeducation	NA	NA	KQ1	Yes
Kim, 2019, 30249416	Depression/Anxiety	TMS	Sham TMS	NA	NA	KQ1	Yes
Kozinszky, 2012, 22261988	Depression/Anxiety	CBT + IPT + Psychoeducation	TAU	NA	NA	KQ1	Yes
Lenze, 2017, 28038377	Depression	IPT	TAU (Note: Enhanced usual care)	NA	NA	KQ1	No
Letourneau, 2011, 21385294	Depression/Anxiety	Peer support	TAU	NA	NA	KQ1	Yes
Leung, 2016, 26908335	Depression	CBT	TAU	NA	NA	KQ1	No
Loughnan, 2019, 30266030	Depression and Anxiety	CBT	TAU	NA	NA	KQ1	No

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
Loughnan, 2019, 30877878	Depression and Anxiety	CBT	TAU	NA	NA	KQ1	No
Madigan, 2015, 25703488	PTSD	CBT + Psychoeducation (Note: Trauma focused)	Psychoeducation	NA	NA	KQ1	No
Manber, 2004, 15546651	Depression	Acupuncture	Sham acupuncture	Massage	NA	KQ1	No
Manber, 2010, 20177281	Depression	Acupuncture	Sham acupuncture	Massage	NA	KQ1	No
Mennen, 2021, 33221606	Depression	IPT	TAU	NA	NA	KQ1	No
Merza, 2023, 37649448	Depression	CBT	TAU	NA	NA	KQ1	No
Milgrom, 2005, 16368032	Depression	CBT (Note: Individual format)	CBT (Note: Group format)	Non-directive counseling	TAU	KQ1	No
Milgrom, 2011, 21615968	Depression	CBT (Note: Nurse led)	CBT (Note: Psychologist led)	TAU	NA	KQ1	No
Milgrom, 2015, 25586754	Depression/Anxiety	CBT	Sertraline	CBT	NA	KQ2	Yes
Milgrom, 2015, 25709044	Depression	CBT	TAU	NA	NA	KQ1	No
Milgrom, 2016, 26952645	Depression	CBT	TAU	NA	NA	KQ1	No
Milgrom, 2021, 34889742	Depression/Anxiety	CBT	CBT	TAU	NA	KQ1	Yes
Mitchell, 2012,	Depression/Anxiety	Exercise (Note: Yoga)	Psychoeducation	NA	NA	KQ1	Yes
Mulcahy, 2010, 19697094	Depression	IPT	TAU	NA	NA	KQ1	No
Ngai, 2015, 26278623	Depression	CBT	TAU	NA	NA	KQ1	No
Nieminen, 2016, 27152849	PTSD	CBT (Note: Trauma focused)	TAU	NA	NA	KQ1	No
O'Hara, 2000, 11074869	Depression	IPT	TAU	NA	NA	KQ1	No
O'Hara, 2019, 30447565	Depression/Anxiety	Psychoeducation + Pharmacologic placebo	Psychoeducation + Sertraline	IPT	NA	KQ1	Yes
O'Mahen, 2013, 23319454	Depression	CBT	TAU	NA	NA	KQ1	No
O'Mahen, 2013, 23602514	Depression	Behavioral Activation	TAU	NA	NA	KQ1	No

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
O'Mahen, 2014, 24148703	Depression	Behavioral Activation	TAU	NA	NA	KQ1	No
O'Mahen, 2022, 35177019	Depression/Anxiety	CBT + Psychoeducation + Problem solving therapy + Mindfulness	TAU	NA	NA	KQ1	Yes
O'Mahen, 2022, 35177019	Anxiety	Problem-solving therapy + self-care + psychoeducation	TAU	NA	NA	KQ1	No
Okatsau, 2023, 37163508	Anxiety	CBT	TAU	NA	NA	KQ1	No
Ormsby, 2020, 32658830	Depression/Anxiety	Acupuncture	Progressive muscle relaxation	TAU	NA	KQ1	Yes
Pan, 2023, 37525110	Depression	Mindfulness	TAU	NA	NA	KQ1	Yes
Pearson, 2013, 22884235	Depression	CBT	TAU	NA	NA	KQ1	No
Perkins, 2023, 37270855	Depression	Song writing	TAU	NA	NA	KQ1	Yes
Prendergast, 2001,	Depression	CBT	TAU	NA	NA	KQ1	No
Pugh, 2016, 26930488	Depression	CBT	TAU	NA	NA	KQ1	No
Richter, 2012, 23078196	Depression/Anxiety	CBT+Psychoeducation	TAU	NA	NA	KQ1	Yes
Rojas, 2007, 17993363	Depression/Anxiety	Psychoeducation + Clinical monitoring	TAU	NA	NA	KQ1	Yes
Segre, 2015, 25486371	Depression	Non-directive counseling	TAU	NA	NA	KQ1	No
Sharp, 2010, 20860888	Depression/Anxiety	Non-directive counseling	Antidepressant (Note: SSRI recommended)	NA	NA	KQ2	Yes
Shaw, 2014, 25049338	Depression	CBT	TAU	NA	NA	KQ1	No
Spinelli, 2003, 12611838	Depression/Anxiety	IPT	Psychoeducation	NA	NA	KQ1	Yes
Spinelli, 2013, 23656847	Depression/Anxiety	IPT	Psychoeducation	NA	NA	KQ1	Yes
Stein, 2018, 29413138	Depression	CBT	CBT	NA	NA	KQ1	No
Stuart, 2023, 38074280	Depression	IPT	IPT	NA	NA	KQ1	Yes
Suchan, 2022, 36066958	Depression/Anxiety	CBT+Psychoeducation	TAU	NA	NA	KQ1	Yes

Author, Year, PMID	Study Population	Arm 1	Arm 2	Arm 3	Arm 4	Key Question	Evidence Map
Toth, 2013, 24229549	Depression	IPT	TAU (Note: Enhanced usual care)	NA	NA	KQ1	No
Trevillion, 2020, 31634678	Depression	CBT	TAU	NA	NA	KQ1	No
Upshur, 2016, 27480668	PTSD	Psychoeducation	TAU	NA	NA	KQ1	No
Van Horne, 2022, 34866254	Depression/Anxiety	Problem solving therapy	TAU	NA	NA	KQ1	Yes
Van Lieshout, 2021, 34495285	Depression	CBT (Note: 1 day workshop)	TAU	NA	NA	KQ1	No
Van Lieshout, 2022, 35060398	Depression	CBT	TAU	NA	NA	KQ1	No
Van Lieshout, 2023, 36878891	Depression	CBT	TAU	NA	NA	KQ1	No
Vigod, 2019, 31257092	Depression/Anxiety	TMS	Sham TMS	NA	NA	KQ1	Yes
Vigod, 2021, 33949762	Depression	IPT	TAU	NA	NA	KQ1	No
Wiklund, 2010, 20636249	Depression	CBT	TAU	NA	NA	KQ1	No
Wirz-Justice, 2011, 21535997	Depression	Bright light therapy	Light therapy	NA	NA	KQ1	No
Wisner, 2017, 28796940	Depression/Anxiety	Psychoeducation	TAU	NA	NA	KQ1	Yes
Wozney, 2017, 28593360	Depression	CBT	TAU	NA	NA	KQ1	No

Appendix D. Outcomes

Table D-1. Depressive disorders: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
BA vs. TAU	Dimidjian, 2017, 28045285	✓	✓	○	○	✓
	O'Mahen, 2013, 23602514	✓	○	○	○	○
	O'Mahen, 2014, 24148703	✓	○	○	○	○
Bright light vs placebo light therapy	Bais, 2020, 33115894	✓	○	○	○	○
	Donmez, 2022, 35339911	✓	✓	○	○	○
	Wirz-Justice, 2011, 21535997	✓	✓	○	○	○
CBT vs. Counseling vs. TAU	Cooper, 2003, 12724244	✓	✓	✓	○	○
	Hayden, 2012, 22526914	✓	○	○	○	○
	Milgrom, 2005, 16368032	✓	○	○	○	○
CBT vs. TAU	Alhusen, 2021, 32409986	✓	○	✓	○	○
	Amani, 2021, 34758210	✓	○	✓	○	○
	Burns, 2013, 23339584	✓	○	✓	○	○
	Cho, 2008, 18729297	✓	○	○	○	○
	Danaher, 2023, 36174746	✓	○	○	○	○
	Forsell, 2017, 28628768	✓	○	○	○	○
	Honey, 2002, 12437794	✓	○	○	○	○

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
	Huh, 2023, 37498661	✓	○	○	○	○
	Leung, 2016, 26908335	✓	○	○	○	○
	Merza, 2023, 37649448	✓	○	○	○	○
	Milgrom, 2015, 25709044	✓	○	○	○	○
	Milgrom, 2016, 26952645	✓	○	○	○	○
	Ngai, 2015, 26278623	✓	○	○	○	○
	O'Mahen, 2013, 23319454	✓	○	○	○	○
	Pearson, 2013, 22884235	○	✓	○	○	○
	Prendergast, 2001,	✓	○	○	○	○
	Pugh, 2016, 26930488	✓	○	○	○	○
	Trevillion, 2020, 31634678	✓	○	○	○	○
	Van Lieshout, 2022, 35060398	✓	○	✓	○	○
	Van Lieshout, 2023, 36878891	✓	○	✓	○	○
	Wiklund, 2010, 20636249	✓	○	○	○	○
	Wozney, 2017, 28593360	✓	✓	○	○	○
	Van Lieshout, 2021, 34495285	✓	○	✓	○	○
	Husain, 2023, 37413896	✓	○	○	○	○
	Ammerman, 2013, 23768664	✓	✓	✓	○	✓
	Milgrom, 2011, 21615968	✓	○	○	○	○
Counseling vs TAU	Segre, 2015, 25486371	✓	○	○	○	○
Exercise vs. TAU	Armstrong, 2003, 12956024	✓	○	○	○	○
	Broberg, 2021, 32862425	✓	✓	○	○	○

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
	Da Costa, 2009, 19728220	✓	○	○	○	✓
	Daley, 2008, 18399022	✓	○	○	○	○
	Daley, 2015, 25804297	✓	○	○	○	○
	Forsyth, 2017, 28278021	✓	✓	○	○	○
	Buttner, 2015, 25886805	✓	○	○	○	○
IPT vs. TAU	Dennis, 2020, 32029010	✓	✓	○	○	○
	Hankin, 2023, 37074698	✓	✓	○	○	○
	Lenze, 2017, 28038377	✓	○	○	○	✓
	Mennen, 2021, 33221606	✓	○	○	○	○
	Mulcahy, 2010, 19697094	✓	○	✓	○	○
	O'Hara, 2000, 11074869	✓	○	○	○	○
	Toth, 2013, 24229549	✓	○	✓	○	○
	Vigod, 2021, 33949762	✓	✓	○	○	○
	Grote, 2009, 19252043	✓	✓	○	○	✓
Specific vs. Nonspecific Acupuncture	Manber, 2004, 15546651	✓	✓	○	○	○
	Manber, 2010, 20177281	✓	✓	○	○	○
	Chung, 2012, 22840621	✓	✓	○	○	○

Abbreviations: BA = behavioral activation, CBT = cognitive behavioral therapy, TAU = treatment as usual, IPT = interpersonal therapy, counseling = non-directive counseling

✓ = outcome reported, ○ = outcome not reported

Table D-2. Anxiety Disorders: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
Multi vs. TAU	O'Mahen, 2022, 35177019	✓	○	○	○	○
CBT vs. TAU	Okatsau, 2023, 37163508	✓	○	○	○	○

Abbreviations: Multi = multicomponent intervention, CBT = cognitive behavioral therapy, TAU = treatment as usual

✓ = outcome reported, ○ = outcome not reported

Table D-3. Depressive and anxiety disorders: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
Exercise vs. TAU	Field, 2013, 23337557	✓	○	○	○	○
CBT vs. TAU	Green, 2020, 31957479	✓	○	○	○	○
	Loughnan, 2019, 30266030	✓	○	○	○	○
	Loughnan, 2019, 30877878	✓	○	○	○	○

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual

✓ = outcome reported, ○ = outcome not reported

Table D-4. Depressive or anxiety disorders: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
CBT vs. TAU	Bittner, 2014, 25062520	✓	○	○	○	○
	Burger, 2020, 31806071	✓	○	○	○	○

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual

✓ = outcome reported, ○ = outcome not reported

Table D-5. Post-traumatic stress disorder: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
CBT vs. TAU	Madigan, 2015, 25703488	✓	○	○	○	○
	Nieminen, 2016, 27152849	✓	○	○	○	○
	Shaw, 2014, 25049338	✓	○	○	○	○
EMDR vs. TAU	Chiorino, 2020, 31805778	✓	○	✓	○	○
EDU vs. TAU	Upshur, 2016, 27480668	✓	○	○	○	○
Counseling vs. TAU	Gamble, 2005, 15725200	✓	✓	○	○	○

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual, EMDR = eye movement desensitization and reprocessing, EDU = psychoeducation, counseling = non-directive counseling

✓ = outcome reported, ○ = outcome not reported

Table D-6. Obsessive-compulsive disorder: Prioritized outcomes by study

Comparisons	Author, Year, PMID	Scores of Psychological Assessments	Cure or Resolution of Symptoms	Parent Infant Bonding	Suicide Related Outcomes	Adherence to Treatment
CBT vs. TAU	Challacombe, 2017, 28137316	✓	○	✓	○	○

Abbreviations: CBT = cognitive behavioral therapy, TAU = treatment as usual

✓ = outcome reported, ○ = outcome not reported

Appendix E. Risk of Bias Table

Table E-1. Risk of bias assessment for all included studies

Author, Year, PMID	Randomization	Allocation Concealment	Blinding, Participants	Blinding, Outcome Assessors	Attrition Bias	Reporting Bias	Intention To Treat	Other Bias	Overall RoB
Alhusen, 2021, 32409986	Low	Low	Unclear	Low	Low	Low	Low	Low	Low
Amani, 2021, 34758210	Low	Unclear	High	Low	Low	Low	High	Low	High
Ammerman, 2013, 23768664	Low	Unclear	High	Low	Low	Low	Low	Low	Moderate
Armstrong, 2003, 12956024	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Bais, 2020, 33115894	Low	Low	Low	Low	Low	Low	Low	Low	Low
Bittner, 2014, 25062520	Low	Unclear	High	Low	High	Low	Unclear	Low	Moderate
Broberg, 2021, 32862425	Low	Low	High	High	High	Low	Low	Low	High
Burger, 2020, 31806071	Low	Unclear	High	Low	High	Low	Low	Low	Moderate
Burns, 2013, 23339584	Low	Low	Unclear	Unclear	Low	Low	High	Low	Moderate
Buttner, 2015, 25886805	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Canfield, 2023, 37853333	Low	High	High	Low	Low	Low	Low	Low	Moderate
Challacombe, 2017, 28137316	Low	Low	High	Low	Low	Low	High	Low	High
Chiorino, 2020, 31805778	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Cho, 2008, 18729297	Low	Unclear	Unclear	Unclear	Low	Low	High	Low	Moderate
Chung, 2012, 22840621	Low	Low	Low	Low	High	Unclear	Unclear	Low	Moderate
Cooper, 2003, 12724244	Low	Unclear	High	Low	Low	Low	Low	Low	Unclear
Da Costa, 2009, 19728220	Unclear	Low	High	Low	Low	High	Low	Low	High
Daley, 2008, 18399022	Low	Low	High	Low	Low	Low	High	Low	High

Author, Year, PMID	Randomization	Allocation Concealment	Blinding, Participants	Blinding, Outcome Assessors	Attrition Bias	Reporting Bias	Intention To Treat	Other Bias	Overall RoB
Daley, 2015, 25804297	Low	Low	High	Low	Low	Low	High	Low	High
Danaher, 2023, 36174746	Unclear	Unclear	High	Unclear	Low	Low	Low	Low	Moderate
Dennis, 2020, 32029010	Low	Unclear	High	Low	Low	Low	Low	Low	Moderate
Dimidjian, 2017, 28045285	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Donmez, 2022, 35339911	Low	Low	Low	Low	High	Low	High	Low	High
Field, 2013, 23337557	Unclear	Unclear	High	Unclear	Low	Low	High	Low	High
Forsell, 2017, 28628768	Low	High	Unclear	High	Low	Low	Low	Low	High
Forsyth, 2017, 28278021	Low	Low	High	Low	Unclear	Low	Unclear	Low	Moderate
Gamble, 2005, 15725200	Low	Low	High	Low	Low	Unclear	Low	Low	Moderate
Green, 2020, 31957479	Low	Unclear	High	Low	Low	Unclear	Low	Low	Moderate
Grote, 2009, 19252043	Low	Unclear	Unclear	High	Low	Low	Low	Low	Moderate
Hankin, 2023, 37074698	Low	Low	Unclear	Unclear	Low	Low	Low	Low	Moderate
Hayden, 2012, 22526914	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Honey, 2002, 12437794	Unclear	Unclear	Unclear	Unclear	Unclear	Low	Unclear	Low	Unclear
Huberty, 2020, 32503517	Low	Low	High	Low	Low	Low	High	Low	High
Huh, 2023, 37498661	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Husain, 2023, 37413896	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Lenze, 2017, 28038377	Low	Low	High	High	Low	Low	Low	Low	High
Leung, 2016, 26908335	Unclear	Unclear	High	Unclear	Low	Low	Low	Low	Moderate
Loughnan, 2019, 30266030	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate

Author, Year, PMID	Randomization	Allocation Concealment	Blinding, Participants	Blinding, Outcome Assessors	Attrition Bias	Reporting Bias	Intention To Treat	Other Bias	Overall RoB
Loughnan, 2019, 30877878	Low	Low	High	Unclear	Low	Low	High	Low	High
Madigan, 2015, 25703488	Unclear	Unclear	High	Unclear	Low	Low	Unclear	Low	Unclear
Manber, 2004, 15546651	Unclear	Unclear	Low	Low	Unclear	Unclear	Low	Low	Unclear
Manber, 2010, 20177281	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Mennen, 2021, 33221606	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Merza, 2023, 37649448	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Milgrom, 2005, 16368032	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Milgrom, 2011, 21615968	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Milgrom, 2015, 25709044	Low	Low	High	Low	Low	Low	Low	Low	Low
Milgrom, 2016, 26952645	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Mulcahy, 2010, 19697094	Low	Unclear	Unclear	Low	Unclear	Low	Low	Low	Unclear
Ngai, 2015, 26278623	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Nieminen, 2016, 27152849	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
O'Hara, 2000, 11074869	Low	Low	High	Unclear	High	Unclear	Low	Low	Moderate
O'Hara, 2019, 30447565	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Unclear
O'Mahen, 2013, 23319454	Low	Unclear	Low	Unclear	High	Unclear	Low	Low	Moderate
O'Mahen, 2013, 23602514	Low	Low	Unclear	Unclear	High	Unclear	Low	Low	Moderate
O'Mahen, 2014, 24148703	Low	Low	Unclear	Unclear	Unclear	Low	Low	Low	Unclear
O'Mahen, 2022, 35177019	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Okatsau, 2023, 37163508	Low	Low	High	High	Low	High	High	Low	High

Author, Year, PMID	Randomization	Allocation Concealment	Blinding, Participants	Blinding, Outcome Assessors	Attrition Bias	Reporting Bias	Intention To Treat	Other Bias	Overall RoB
Pearson, 2013, 22884235	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Unclear
Prendergast, 2001	Unclear	Unclear	High	Low	Low	Unclear	Low	Low	Unclear
Pugh, 2016, 26930488	Low	Low	High	Unclear	High	Low	Low	Low	High
Segre, 2015, 25486371	Low	Unclear	High	Low	Low	Low	Low	Low	Moderate
Shaw, 2014, 25049338	Low	High	High	High	Low	Low	Low	Low	High
Spinelli, 2013, 23656847	Low	Unclear	Low	Low	Low	Low	Unclear	Low	Unclear
Stein, 2018, 29413138	Low	Low	Low	Low	Low	Low	High	Low	Moderate
Toth, 2013, 24229549	Low	Unclear	High	High	Low	Low	Low	Low	High
Trevillion, 2020, 31634678	Low	Low	High	Low	Low	Low	Low	Low	Moderate
Upshur, 2016, 27480668	Unclear	Unclear	Unclear	Unclear	Low	Low	High	Low	Moderate
Van Lieshout, 2021, 34495285	Low	Low	High	Unclear	Low	Low	Low	Low	Moderate
Van Lieshout, 2022, 35060398	Low	Low	High	High	Low	Low	Low	Low	High
Van Lieshout, 2023, 36878891	Low	Low	High	Low	Low	Low	High	Low	High
Vigod, 2021, 33949762	Low	Low	High	Unclear	Low	Low	High	Low	High
Wiklund, 2010, 20636249	Unclear	Unclear	High	Low	Low	Low	Low	Low	Moderate
Wirz-Justice, 2011, 21535997	Low	Low	Low	Low	Low	Low	Low	Low	Low
Wozney, 2017, 28593360	Low	Low	High	Low	Low	Low	Low	Low	Moderate

PMID = PubMed Identifier

From the Cochrane Risk of Bias Tool (each item rated as Low, High, Unsure, or N/A). Ratings are color coded for emphasis only.

- Random: Random sequence generation (selection bias): Selection bias (biased allocation to interventions) due to inadequate generation of a randomized sequence;
- Allocation: Allocation concealment (selection bias): Selection bias (biased allocation to interventions) due to inadequate concealment of allocations prior to assignment;
- Blinding of participants (performance bias): Performance bias due to knowledge of the allocated interventions by participants during the study;
- Blinding of personnel/care providers (performance bias): Performance bias due to knowledge of the allocated interventions by personnel/care providers during the study;
- Blinding of outcome assessor (detection bias): Detection bias due to knowledge of the allocated interventions by outcome assessors;

- Dropout: Incomplete outcome data (attrition bias): Attrition bias due to amount, nature or handling of incomplete outcome data;
- Reporting Bias: Selective outcome reporting (outcome reporting bias):

Appendix F. Results Tables

Table F-1. Acupuncture versus nonspecific acupuncture for depressive disorders: Depressive symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Specific N	Specific Mean (SD)	Non-Specific N	Non-Specific (SD)	MD	SMD (95% CI)
Chung, 2012, 22840621	HAM-D	4	8	11.3 (4.8)	10	9.6 (3.4)	1.7	0.40 (-0.54, 1.33)
	EPDS	4	10	11.1 (5.0)	10	11.4 (4.9)	-0.3	-0.06 (-0.93, 0.82)
	HADS-Depression	4	10	8.8 (3.8)	10	7.3 (1.6)	1.5	0.49 (-0.40, 1.38)
Manber, 2004, 15546651	HAM-D	8	16	9.6 (7.8)	19	12.6 (7.5)	-3.0	-0.38 (-1.06, 0.29)
	BDI	8	16	9.2 (6.1)	19	12.2 (5.4)	-3.0	-0.51 (-1.19, 0.16)
Manber, 2010, 20177281	HAM-D	4	52	Mean diff = -9.38	49	Mean diff = -7.35	-	-

Abbreviations: PMID = PubMed ID, HAM-D = Hamilton depression rating scale, EPDS = Edinburgh Postnatal Depression Scale, HADS = Hospital Anxiety and Depression Scale, BDI = Beck Depression Inventory, SD = standard deviation, MD = mean difference, SMD = Standardized mean difference, CI = confidence interval

Table F-2. Acupuncture versus nonspecific acupuncture for depressive disorders: Side effects

Study, Year, PMID	Measure	Timepoint (Weeks)	Acupuncture n/N Events (%)	Sham Acupuncture n/N Events (%)	RR (95% CI)
Manber, 2010, 20177281	NR	Post-treatment	13/49 (26.5)	4/44 (9.1)	2.92 (1.03, 8.29) a

Abbreviations: PMID = PubMed ID, NR = Not reported, RR = relative risk, CI = confidence interval

^aStatistically significant difference.

Table F-3. Acupuncture versus nonspecific acupuncture for depressive disorders: Illness severity, global and subjective improvement

Study, Year, PMID	Measure	Timepoint (Weeks)	Acupuncture N	Acupuncture Mean (SD)	Sham N	Sham Mean (SD)	MD	SMD (95% CI)
Chung, 2012, 22840621	Severity of illness	4	8	2.5 (1.2)	10	1.8 (0.8)	0.7	0.67 (-0.29, 1.62)
	Global improvement	4	8	2.8 (1.3)	10	2.0 (0.9)	0.8	0.7 (-0.26, 1.66)
	Subjective improvement	4	8	2.5 (0.8)	10	2.3 (0.9)	0.2	0.22 (-0.71, 1.16)

Abbreviations: PMID = PubMed ID, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-4. Behavioral activation versus TAU for depressive disorders: Anxiety symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
O'Mahen, 2014, 24148703	GAD-7	17	31	8.71 (4.61)	28	11.29 (5.49)	-2.58	-0.50 (-1.02 - 0.01)

Abbreviations: PMID = PubMed ID, GAD-7 = general anxiety disorder-7, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-5. Behavioral activation versus TAU for depressive disorders: Remission rate of depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	BA n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Dimidjian, 2017, 28045285	PHQ-9 Score <5	10	36/86 (41.9%)	20/77 (26.0%)	1.61 (1.03- 2.53) ^a

Abbreviations: PMID = PubMed ID, PHQ-9 = Patient Health Questionnaire, BA = behavioral activation, TAU = treatment as usual, RR = relative risk, CI = confidence interval

^aStatistically significant difference.

Table F-6. Behavioral activation versus TAU for depressive disorders: Perceived stress at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Dimidjian, 2017, 28045285	PSS	10	70	19.08 (7.11)	68	22.79 (5.90)	-3.71	-0.56 (-0.90, -0.22) ^a
Dimidjian, 2017, 28045285	PSS	22	64	15.96 (8.51)	66	20.50 (7.10)	-4.54	-0.58 (-0.93, -0.22) ^a

Abbreviations: PMID = PubMed ID, PSS = perceived stress scale, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

^aStatistically significant difference.

Table F-7. Behavioral activation versus TAU for depressive disorders: Behavioral and environmental measures at the end of treatment and follow-up timepoints

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Dimidjian, 2017, 28045285	BADS	10	70	29.28 (10.49)	68	24.40 (8.18)	4.88	0.51 (0.17, 0.85) ^a
Dimidjian, 2017, 28045285	BADS	22	64	33.42 (9.41)	65	28.49 (8.88)	4.93	0.53 (0.19, 0.87) ^a
Dimidjian, 2017, 28045285	EROS	10	70	26.79 (6.45)	68	23.59 (4.71)	3.2	0.56 (0.22, 0.90) ^a
Dimidjian, 2017, 28045285	EROS	22 (3 month follow-up)	64	23.59 (4.71)	65	26.25 (5.62)	-2.66	-0.51 (-0.85, -0.17)

Abbreviations: PMID = PubMed ID, BADS = Behavioral activation for depression scale, EROS = Environmental Reward Observation Scale, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

^aStatistically significant difference.

Table F-8. Behavioral activation versus TAU for depressive disorders: Social impairment at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
O'Mahen, 2014, 24148703	WSAS	17	31	13.13 (6.70)	28	17.18 (7.25)	-4.05	-0.57 (-1.09, -0.05) ^a

Abbreviations: PMID = PubMed ID, WSAS = Work and Social Adjustment Scale, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

^aStatistically significant difference.

Table F-9. Behavioral activation versus TAU for depressive disorders: Perceived availability of social support at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
O'Mahen, 2014, 24148703	SPS	17	31	73.63 (9.83)	28	68.39 (10.49)	5.24	0.50 (-0.01, 1.03)

Abbreviations: PMID = PubMed ID, SPS = Social Provision Scale, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-10. Behavioral activation versus TAU for depressive disorders: Adherence

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Dimidjian, 2017, 28045285	Number of sessions completed (out of 12)	10	87	6.43 (3.64)	-	-	-	-

Abbreviations: PMID = PubMed ID, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-11. Behavioral activation versus TAU for depressive disorders: Satisfaction with treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BA N	BA Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Dimidjian, 2017, 28045285	CSQ-8	10	87	27.76 (3.83)	-	-	-	-

Abbreviations: PMID = PubMed ID, CSQ-8 = Client Satisfaction Questionnaire, BA = behavioral activation, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-12. Bright light therapy versus placebo light therapy for depressive disorders: Remission rates for depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	BLT n/N Events (%)	PLT n/N Events (%)	RR (95% CI)
Wirz-Justice, 2011, 21535997	SIGH-ADS ≤8	5	5/16 (31.1)	2/11 (18.2)	1.72 (0.40, 7.32)
	HAM-D ≤8	5	11/16 (68.8)	4/11 (36.4)	1.89 (0.81, 4.42)
Donmez, 2022, 35339911	HAM-D <8	12	8/12 (66.7)	2/11 (18.2)	3.67 (0.98, 13.67)
	MADRS <10	12	5/12 (41.7)	0/11 (0)	-
	EPDS <12	12	8/12 (66.6)	1/11 (9.1)	7.33 (1.08, 49.58) ^a

Abbreviations: PMID = PubMed ID, BLT = bright light therapy, PLT = placebo light therapy, RR= relative risk, CI = confidence interval, SIGH-ADS = Structured Interview Guide for the Hamilton Depression Rating Scale with Atypical Depression Supplement, HAM-D = Hamilton Depression Rating Scale, MADRS = Montgomery–Åsberg Depression Rating Scale, EPDS = Edinburgh Postnatal Depression Scale

*Statistically significant difference.

Table F-13. Bright light therapy versus placebo light therapy for depressive disorders: Response rate in depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	BLT n/N Events (%)	PLT n/N Events (%)	RR (95% CI)
Donmez, 2022, 35339911	> 50% EPDS	12	5/12 (41.7)	1/11 (9.1)	4.58 (0.63- 33.37)
Donmez, 2022, 35339911	> 50% HDRS	12	7/12 (58.3)	2/11 (18.2)	3.21 (0.84-12.27)
Donmez, 2022, 35339911	> 50% MADRS	12	9/12 (75.0)	2/11 (18.2)	4.13 (1.13-15.07)
Wirz-Justice, 2011, 21535997	> 50% HDRS	5	12/16 (75)	4/11 (36.4)	2.06 (0.90-4.74)
Wirz-Justice, 2011, 21535997	> 50% SIGH-ADS	5	13/16 (81.3)	5/11 (45.4)	1.79 (0.90-3.56)

Abbreviations: PMID = PubMed ID, BLT = bright light therapy, PLT = placebo light therapy, RR = relative risk, CI = confidence interval, SIGH-ADS = Structured Interview Guide for the Hamilton Depression Rating Scale with Atypical Depression Supplement, MADRS = Montgomery–Åsberg Depression Rating Scale, EPDS = Edinburgh Postnatal Depression Scale, HDRS = the Hamilton Depression Rating Scale

Table F-14. Bright light therapy versus placebo light therapy for depressive disorders: Satisfaction with treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BLT N	BLT Mean (SD)	PLT N	PLT Mean (SD)	MD	SMD (95% CI)
Bais, 2020, 33115894	Would you recommend treatment to others? (score 1-10)	6	33	8 (1.3)	34	7 (2.7)	1	0.08 (-0.40-0.56)

Abbreviations: PMID = PubMed ID, BLT = bright light therapy, PLT = placebo light therapy, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-15. Bright light therapy versus placebo light therapy for depressive disorders: Satisfaction with treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	BLT n/N Events (%)	PLT n/N Events (%)	Effect size (95% CI)
Bais, 2020, 33115894	Will you continue using light therapy?	6	NR/NR (57.1)	NR/NR (61.5)	-

Abbreviations: PMID = PubMed ID, BLT = bright light therapy, PLT = placebo light therapy, CI = confidence interval, NR = not reported

Table F-16. CBT versus counseling for depressive disorders: Remission rate of depressive symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT n/N Events (%)	Counseling n/N Events (%)	RR (95% CI)
Cooper, 2003, 12724244	SCID	18 wks	24/42 (57)	26/48 (54)	1.05 (0.73, 1.53)

Abbreviations: PMID = PubMed ID, CBT = CBT = Cognitive behavioral therapy, RR= risk ratio, CI = confidence intervals

Table F-17. Counseling versus TAU for depressive disorders: Anxiety symptoms at end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	Counseling N	Counseling Mean (SD)	MD	SMD (95% CI)
Milgrom, 2005, 16368032	BAI	Post-intervention	31	12.26 (9.63)	72	12.90 (13.58)	-0.64	-0.05 (-0.47, 0.37)

Abbreviations: PMID = PubMed ID, BAI: Beck Anxiety Inventory, CBT = Cognitive behavioral therapy, SD = standard deviation, SMD = standardized mean difference, CI = confidence interval

Table F-18. CBT versus counseling for depressive disorders: Parent-infant bonding problems

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT n/N Events (%)	Counseling n/N Events (%)	RR (95% CI)
Cooper, 2003, 12724244	Maternal reports of problems ^a	End of treatment	12/29 (41)	18/25 (72)	0.57 (0.35, 0.95) ^b

Abbreviations: PMID = PubMed ID, CBT = Cognitive behavioral therapy, RR = risk ratio, CI = confidence intervals

^aAdjusted for relationship problems prior to treatment.

^bStatistically significant difference.

Table F-19. CBT versus counseling for depressive disorders: Insecure infant attachment type

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT n/N Events (%)	Counseling n/N Events (%)	RR (95% CI)
Cooper, 2003, 12724244	The Ainsworth Strange Situation secure attachment type	72	22/41 (54)	16/39 (41)	1.31 (0.82, 2.11)

Abbreviations: PMID = PubMed ID, CBT = Cognitive behavioral therapy, RR = risk ratio, CI = confidence intervals

Table F-20. Counseling versus TAU for depressive disorders: Child emotional and behavioral difficulties

Study, Year, PMID	Measure	Timepoint	CBT N	CBT Median (Min, Max)	Counseling N	Counseling Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	BSQ	72	42	5 (0, 13)	46	4 (0,11)	-1	-
Cooper, 2003, 12724244	PBCL scale	5yr	29	4 (0,11)	26	3 (0,14)	-1	-
Cooper, 2003, 12724244	Rutter A2 scale	5yr	31	8 (0,16)	33	9 (3, 33)	1	-
Hayden, 2012, 22526914	BRS	End of treatment	20	56.1 th percentile	14	29.6 th percentile	-	-

Abbreviations: PMID = PubMed ID, Rutter A² scale = Self-report Rutter A² scale, PBCL = Preschool Behavior Checklist, BSQ = Behavioral Screening Questionnaire, BRS = Behavioral Rating Scale, CBT = cognitive behavioral therapy, SMD = standardized mean difference, CI = confidence interval

Table F-21. Counseling versus TAU for depressive disorders: Child cognitive development

Study, Year, PMID	Measure	Timepoint	CBT N	CBT Median (Min, Max)	Counseling N	Counseling Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	Bayley scale	72 weeks	42	114 (64, 150)	46	116 (73, 150)	2	-
	General Cognitive Index of the McCarthy Scales	5yr	35	107 (54, 148)	33	111(69,145)	4	-

Abbreviations: PMID = PubMed ID, Bayley= The Mental Development Index of the Bayley Scales of Infant Development, CBT = Cognitive behavioral therapy, SMD = standardized mean difference, CI = confidence interval

Table F-22. CBT versus TAU for depressive disorders: Perceived stress at the end of treatment

Study, Year, PMID	Measure	Timepoint	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Pugh, 2016, 26930488	DASS- Stress subscale	7-10	19	12.32 (6.26)	21	18.19 (5.79)	5.87	-0.96 (-1.61, -0.30) ^a

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, DASS = Depression Anxiety Stress Scales

^aStatistically significant difference.

Table F-23. CBT versus TAU for depressive disorders: Parenting stress

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Pugh, 2016, 26930488	Parental distress	7-10	19	31.79 (8.93)	21	36.40 (7.49)	4.61	-0.55 (-1.18, 0.08)
	Parent-child dysfunctional interaction	7-10	19	18.58 (5.98)	21	22.20 (6.73)	3.62	-0.56 (-1.19, 0.08)
	Perception of a difficult child	7-10	19	26.26 (6.89)	21	28.80 (8.82)	2.54	-0.31 (-0.94, 0.31)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-24. CBT versus TAU for depressive disorders: Relationship quality at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Cho, 2008, 18729297	Dissatisfaction with communication (MSI-R)	4 (postpartum)	12	14.3 (3.7)	10	18.3 (4.8)	4	-0.91 (-1.79, -0.03) ^a
	Marital dissatisfaction (MSI-R)	4 (postpartum)	12	10.3 (4.6)	10	16.3 (0.5)	6	-1.69 (-2.67, -0.79) ^a

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, MSI-R = Snyder's Marital Satisfaction Inventory-Revised

^aStatistically significant difference.

Table F-25. CBT versus TAU for depressive disorders: Social functioning at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Forsell, 2017, 28628768	WSAS	End of treatment	22	18.9 (9.6)	20	23.1 (6.9)	-6.2	-0.49 (-1.10, 0.13)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, SPS = Social Provisions Scale, WSAS = Work and Social Adjustment Scale

Table F-26. CBT versus TAU for depressive disorders: Adherence (average number of sessions)

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Ammerman, 2013, 23768664	Completed all treatment sessions	15	43	11.2 (5.5)	-	-	-	-

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-27. CBT versus TAU for depressive disorders: Adherence (completed all sessions)

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Ammerman, 2013, 23768664	Completed all treatment sessions	15	25/47 (53%)	-	-

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, RR = relative risk, CI = confidence interval

Table F-28. CBT versus TAU for depressive disorders: Maternal-fetal bond at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Alhusen, 2021, 32409986	MFAS	36 weeks gestation	30	73.6 (6.2)	30	78.2 (6.4)	4.6	-0.72 (-1.24, -0.20) ^a
Burns, 2013, 23339584	PAI	15	16	60.4 (3.0)	10	47.2 (3.3)	-13.2	4.10 (2.71, 5.50) ^a

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, MFAS= Maternal-Fetal Attachment Scale, PAI = Prenatal Attachment Inventory.

^aStatistically significant difference.

Table F-29. CBT versus TAU for depressive disorders: Child cognitive development

Study, Year, PMID	Measure	Timepoint	CBT N	CBT Median (Min, Max)	TAU N	TAU Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	Bayley Scale	72 weeks	24	114 (64, 150)	48	116 (58, 150)	2	-
Cooper, 2003, 12724244	General cognitive index of the McCarthy Scales	5 years	35	107 (54, 148)	39	108 (50, 140)	1	-

Abbreviations: PMID = PubMed ID, Bayley= The Mental Development Index of the Bayley Scales of Infant Development, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval,

Table F-30. CBT versus TAU for depressive disorders: Child emotional and behavioral difficulties scores

Study, Year, PMID	Measure	Timepoint	CBT N	CBT Median (Min, Max)	TAU N	TAU Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	PBCL	5yr	29	4 (0, 11)	33	3 (0, 24)	1	-
Cooper, 2003, 12724244	Rutter A ² Scale	5yr	31	8 (0, 16)	35	11 (1, 28)	3	-

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, PBCL= Pre-school Behavior Checklist, Rutter A² Scale = Self-report Rutter A²scale,

Table F-31. Counseling versus TAU for depressive disorders: Remission rates for depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Cooper, 2003, 12724244	SCID	18	26/48 (54)	20/50 (40)	1.35 (0.88, 2.08)

Abbreviations: PMID = PubMed ID, SCID= Structured Clinical Interview for DSM–III–R, TAU = treatment as usual, RR= relative risk, CI = confidence interval

Table F-32. Counseling versus TAU for depressive disorders: Clinically meaningful difference in depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Segre, 2015, 25486371	HAM-D	8	14/39 (36)	3/21 (14)	2.51 (0.81, 7.77)
	EPDS	8	25/39 (64)	9/21 (43)	1.50 (0.87, 2.58)
	IDAS-GD	8	27/39 (69)	6/21 (29)	2.42 (1.19, 4.92) ^a

Abbreviations: PMID = PubMed ID, HAM-D= Hamilton Rating Scale for Depression, EPDS= the Edinburgh Postnatal Depression Scale, IDAS-GD= The Inventory of Depression and Anxiety Symptoms General Depression scale, TAU = treatment as usual, RR = relative risk, CI = confidence interval

^aStatistically significant difference.

Table F-33. Counseling versus TAU for depressive disorders: Anxiety symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Milgrom, 2005, 16368032	BAI	Post-intervention	72	12.90 (13.58)	18	18.21 (9.58)	-5.31	-0.41 (-0.93, 0.11)

Abbreviations: PMID = PubMed ID, BAI: Beck Anxiety Inventory, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-34. Counseling versus TAU for depressive disorders: Quality-of-life at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Segre, 2015, 25486371	Q-LES-Q	8	39	42.49 (11.57)	21	41.52 (10.48)	0.97	0.09 (-0.45, 0.62)

Abbreviations: PMID = PubMed ID, Q-LES-Q= The Quality of Life, Enjoyment, and Satisfaction Questionnaire, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean differences, CI = confidence interval

Table F-35. Counseling versus TAU for depressive disorders: Social functioning at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Segre, 2015, 25486371	WSAS	8	39	5.56 (10.95)	21	13.67 (10.98)	1.89	-0.7 (-1.3, -0.2)

Abbreviations: PMID = PubMed ID, WSAS= Work and Social Adjustment Scale, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean differences, CI = confidence interval

Table F-36. Counseling versus TAU for depressive disorders: Parent-infant bonding problems

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Cooper, 2003, 12724244	Maternal reports of problems	End of treatment	18/25 (72)	19/23 (83)	0.87 (0.64, 1.19)
	Secure attachment as ascertained by Ainsworth's strange situation	72 weeks	NR/NR (41%)	NR/NR (43%)	-

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, RR = relative risk, CI = confidence interval, NR = Not reported

Table F-37. Counseling versus TAU for depressive disorders: child emotional and behavioral difficulties at 5-year follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Median (Min, Max)	TAU N	TAU Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	BSQ	72	46	4 (0, 11)	48	6 (1, 15)	-2	-
	Rutter A ² scale	5yr	33	11 (1, 28)	35	9 (3, 33)	-2	-
	PBCL scale	5yr	26	3 (0, 24)	33	3 (0, 14)	0	-

Abbreviations: PMID = PubMed ID, BSQ= Behavioral Screening Questionnaire, Rutter A² scale = Self-report Rutter A² scale, PBCL = Preschool Behavior Checklist, TAU = treatment as usual, Min = minimum, Max =maximum, SMD = standardized median differences, CI = confidence interval

Table F-38. Counseling versus TAU for depressive disorders: Child cognitive development at end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Median (Min, Max)	TAU N	TAU Median (Min, Max)	Median Difference	SMD (95% CI)
Cooper, 2003, 12724244	Bayley scale	72	46	114 (64, 150)	48	116 (85,150)	-2	-
	General Cognitive Index of the McCarthy Scales	5yr	33	107 (54, 148)	39	108 (50,140)	-1	-

Abbreviations: PMID = PubMed ID, Bayley= The Mental Development Index of the Bayley Scales of Infant Development, TAU = treatment as usual, Min = minimum, Max =maximum, SMD = standardized median differences, CI = confidence interval

Table F-39. Exercise versus TAU for depressive disorders: Remission rate for depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Exercise n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Broberg, 2021, 32862425	EPDS	29-34 gestational weeks	30/133 (23.0)	40/137 (29.0)	0.77 (0.51, 1.16)
Broberg, 2021, 32862425	EPDS	8 weeks postpartum	21/133 (16.0)	49/137 (36)	0.44 (0.28, 0.69)

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, RR = relative risk, CI = confidence interval, EPDS = Edinburgh Postnatal Depression Scale

Table F-40. Exercise versus TAU for depressive disorders: Anxiety scores at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Exercise N	Median (Min, Max)	TAU N	Median (Min, Max)	MD	SMD (95% CI)
Broberg, 2021, 32862425	STAI	8	133	35.4 (NR)	137	36.7	-1.3	-
Broberg, 2021, 32862425	STAI	29-34	133	37.4 (NR)	137	37.3	0.04	-

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, STAI = State-Trait Anxiety Inventory, NR = not reported.

Table F-41. Exercise versus TAU for depressive disorders: Health-related quality-of-life at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	Exercise N	Exercise Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Daley, 2015, 25804297	EQ-5D	26	41	0.78 (0.21)	41	0.72 (0.22)	-0.1	0.28 (-0.16; 0.71)
Daley, 2015, 25804297	EQ-5D	52	40	0.81 (0.21)	38	0.78 (0.23)	-0.03	0.14 (-0.31; 0.58)
Daley, 2015, 25804297	MCS-12	26	42	41.45 (9.99)	42	37.9 (10.3)	3.6	0.35 (-0.08; 0.78)
Daley, 2015, 25804297	MCS-12	52	41	41.6 (12.13)	38	41.02 (12.36)	0.6	0.05 (-0.40; 0.49)
Daley, 2015, 25804297	PCS-12	26	42	51.34 (9.02)	42	51.59 (8.48)	-0.3	-0.3 (-0.46; 0.40)
Daley, 2015, 25804297	PCS-12	52	40	52.16 (9.16)	38	51.6 (8.57)	0.6	0.06 (-0.38; 0.51)

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, EQ-5D = EuroQoL EQ-5D, MCS-12 = Mental Health Component of the Short Form-12 (SF-12), PCS-12 = Physical Health Component of the SF-12, SF-36 = Short-Form 36

Table F-42. Exercise versus TAU for depressive disorders: Perceived availability of social support at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	Exercise N	Exercise Mean (SD)	TAU N	TAU Mean (SD)	MD (95%CI)	SMD (95% CI)
Armstrong, 2003, 12956024	SSI	12	10	101.6 (19.3)	10	89.0 (17.4)	12.6	0.66 (-0.25; 1.56)

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, SSI= Social Support Interview

Table F-43. Exercise versus TAU for depressive disorders: Number of minutes spent engaging in aerobic exercise per week

Study, Year, PMID	Measure	Timepoint (Weeks)	Exercise N	Exercise Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Da Costa, 2009, 19728220	Minutes of aerobic exercise per week	12	46	124 (96.3)	42	54.6 (55.8)	69.4	0.86 (0.43, 1.30) ^a

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

^aStatistically significant difference.

Table F-44. IPT versus TAU for depressive disorders: Response rate for depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Grote, 2009, 19252043	50% improvement on EPDS	12	20/25 (80)	8/28 (29)	2.80 (1.51, 5.19) ^a

Abbreviations: PMID = PubMed ID, IPT = Interpersonal therapy, TAU= treatment as usual, RR = relative risk, CI = confidence interval, EPDS = Edinburgh Postnatal Depression Scale

^aStatistically significant difference.

Table F-45. IPT versus TAU for depressive disorders: Remission rate for anxiety symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Dennis, 2011, 21535997	STAT <44	12	62/104 (59.6)	35/100 (35)	1.70 (1.25, 2.32)

Abbreviations: PMID = PubMed ID, IPT = Interpersonal therapy, TAU=treatment as usual, RR = relative risk, CI = confidence interval, STAT= State-Trait Anxiety Inventory

Table F-46. IPT versus TAU for depressive disorders: Remission rate for depression and anxiety symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Dennis, 2011, 21535997	EPDS <12 and STAI < 44	12	86/104 (82.7)	55/100 (55)	1.50 (1.23, 1.83) ^a

Abbreviations: PMID = PubMed ID, IPT = Interpersonal therapy, TAU=treatment as usual, RR = relative risk, CI = confidence interval, EPDS = Edinburgh Postnatal Depression Scale, STAT= State-Trait Anxiety Inventory

^aStatistically significant difference.

Table F-47. IPT versus TAU for depressive disorders: Adherence

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Grote, 2009, 19252043	Completed full course	12	17/25 (68)	2/28 (7)	9.52 (2.44, 37.18) ^a
Lenze, 2017, 28038377	Completed at least 4 sessions	37-39 weeks gestation	15/21 (71.4)	-	-

Abbreviations: PMID = PubMed ID, IPT = Interpersonal therapy, TAU= treatment as usual, RR = relative risk, CI = confidence interval

^aStatistically significant difference.

Table F-48. IPT versus TAU for depressive disorders: Mother-infant relationship at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT N	IPT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Mulcahy, 2010, 19697094	MAI	8	23	97.18 (5.35)	27	92.28 (10.14)	4.9	0.58 (0.01, 1.15) ^a
Toth, 2013, 24229549	DAC	32	97	3.32 (0.37)	28	3.38 (0.39)	0.06	-0.10 (-0.52, 0.32)

Abbreviations: PMID = PubMed ID, IPT = interpersonal therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, DAC = Disorganized Attachment Characteristics, MAI = Maternal Attachment Inventory

^aStatistically significant difference.

Table F-49. IPT versus TAU for depressive disorders: Perceived self-efficacy for parenthood at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT N	IPT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Toth, 2013, 24229549	MEQ	32	97	3.32 (0.37)	28	3.38 (0.39)	-0.06	-0.16 (-0.58, 0.26)

Abbreviations: PMID = PubMed ID, IPT = interpersonal therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, MEQ = Maternal Efficacy Questionnaire

Table F-50. IPT versus TAU for depressive disorders: Social functioning at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT N	IPT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Grote, 2009, 19252043	SAS	12	25	2.37 (0.51)	28	3.00 (0.76)	-0.63	-0.95 (-1.52, -0.38)

Abbreviations: PMID = PubMed ID, IPT = interpersonal therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, SAS = Social and Leisure Domain of the Social Adjustment Scale (SAS scores range from 1 to 5, with higher scores indicating greater impairment.)

Table F-51. IPT versus TAU for depressive disorders: Social support at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT N	IPT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Lenze, 2017, 28038377	SSQR	37-39 week of gestation	21	31.66 (0.95)	21	28.61 (1.79)	3.05	2.09 (1.33, 2.85)
Mulcahy, 2010, 19697094	ISEL	8	23	84.64 (19.89)	27	78.32 (21.32)	6.32	0.30 (-0.26, 0.86)

Abbreviations: PMID = PubMed ID, IPT = interpersonal therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, % CI = confidence interval, SSQR = Social Support Questionnaire Revised Scale (SSQR higher scores indicates greater satisfaction with support available (scores range from 0 to 36)), ISEL = Interpersonal Support Evaluation List.

Table F-52. IPT versus TAU for depressive disorders: Toddler difficult temperament

Study, Year, PMID	Measure	Timepoint (Weeks)	IPT N	IPT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Toth, 2013, 24229549	Anger	32	97	4.4 (0.91)	28	4.45 (0.76)	-0.05	-0.06 (-0.05, 0.47)
	Activity level	32	97	4.54 (0.67)	28	4.6 (0.76)	-0.06	-0.09 (-0.51, 0.33)

Abbreviations: PMID = PubMed ID, IPT = interpersonal therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-53. Multicomponent intervention versus TAU for anxiety disorder: All outcomes

Study, Year, PMID	Measure	Timepoint (Weeks)	MULTI N	MULTI Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
O'Mahnen, 2022, 35177019	EPDS	10	45	10.37 (4.34)	51	10.51 (5.23)	-0.14	-0.03 (-0.43, 0.37)
	GAD-7	10	45	6.40 (3.75)	51	7.58 (4.72)	-1.18	-0.27 (-0.68, 0.13)
	PRAQ	10	45	22.99 (3.90)	51	24.66 (4.20)	-1.67	-0.40 (-0.81, -0.01) ^a
	EQ-5D	10	45	7.20 (1.63)	51	6.90 (1.86)	0.03	0.17 (-0.23, 0.57)

Abbreviations: PMID = PubMed ID, MULTI = multicomponent intervention, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, EPDS = Edinburgh postnatal depression scale, GAD-7 = generalized anxiety disorder 7, PRAQ = pregnancy-related anxiety scale, EQ-5D = EuroQol 5 dimensions.

^aStatistically significant difference.

Table F-54. CBT versus TAU for anxiety disorder: All outcomes

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Okatsau, 2023, 37163508	EPDS	1 month postpartum	32	NR (NR)	29	NR (NR)	-	-
	GAD-7	End of treatment	32	4.66 (3.08)	29	5.31 (4.23)	-0.65	-0.17 (-0.68, 0.33)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, NR = not reported, EPDS = Edinburgh postnatal depression scale, GAD-7 = generalized anxiety disorder 7.

Table F-55. Exercise versus TAU for depressive and anxiety disorders: Depressive symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint	Exercise N	Exercise Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Field, 2013, 23337557	Depression (CES-D)	34	37	23.5 (9.0)	38	23.9 (11.4)	0.4	-0.04 (-0.49, 0.41)

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, CES-D = Center for epidemiology depression scale.

Table F-56. Exercise versus TAU for depressive and anxiety disorders: Anxiety symptoms at the end of treatment

Study, Year, PMID	Measure	Timepoint	Exercise N	Exercise Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Field, 2013, 23337557	Anxiety (STAI)	34	37	46.1 (7.9)	38	44.3 (11.4)	-1.8	0.18 (-0.27, 0.63)

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, STAI = State-Trait Anxiety Inventory.

Table F-57. CBT versus TAU for depressive and anxiety disorders: Worry scores at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Green, 2020, 31957479	PSWQ	6	44	53.05 (10.77)	42	65.21 (7.74)	12.16	-1.28 (-1.75, -0.82) ^a

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, PSQW = Penn State Worry Questionnaire

^aStatistically significant difference.

Table F-58. CBT versus TAU for depressive and anxiety disorders: Stress at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Green, 2020, 31957479	PSS	6	44	23.59 (7.69)	42	32.01 (7.23)	8.42	-1.12 (-1.57, -0.66) ^a

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, PSS = Perceived Stress Scale

^aStatistically significant difference.

Table F-59. CBT versus TAU for depressive and/or anxiety disorders: Social support at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Bittner, 2014, 25062520	SOZU	Postpartum	21	4.4 (0.5)	53	4.4 (0.4)	0	0.00 (-0.51, 0.51)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, SOZU = Social Support Scale.

Table F-60. CBT versus TAU for depressive and/or anxiety disorders: Child emotional and behavioral difficulties

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Burger, 2020, 31806071	CBCL	72 weeks postpartum	94	21.8 (11.6)	98	19.8 (12.5)	2	0.17 (-0.11, 0.45)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, CBCL = The Child Behavior Checklist

Table F-61. CBT versus TAU for depressive and/or anxiety disorders: Satisfaction with treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Canfield, 2023, 37853333	CSQ-8	8	15	26 (2.68)	-	-	-	-

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, CSQ-8 = Client Satisfaction Questionnaire.

Table F-62. CBT versus TAU for PTSD: Anxiety symptoms at end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Nieminen, 2016, 27152849	BAI	8	28	10.11 (9.56)	28	11.94 (10.29)	-1.8	-0.18 (-0.71, 0.34)
Shaw, 2014, 25049338	BAI	4-5	57	NR	41	NR	-1.7	NA
Shaw, 2014, 25049338	BAI	26	57	NR	38	NR	-5.3	NA
Madigan, 2015, 25703488	SCARED	26	14	25.73 (13.60)	17	24.00 (16.98)	1.7	0.11 (-0.60; 0.72)
Madigan, 2015, 25703488	SCARED	52	12	23.18 (12.84)	14	16.87 (9.50)	6.3	0.55 (-0.24; 1.33)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, BAI = Beck anxiety inventory, SCARED = Screen for Child Anxiety Related Emotional Disorders

Table F-63. CBT versus TAU for PTSD: Depression symptoms at end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Madigan, 2015, 25703488	Depression	26	14	18.55 (14.42)	17	10.87 (9.42)	7.7	0.62 (-0.10, 1.35)
Madigan, 2015, 25703488	Depression	52	12	18.27 (12.09)	14	10.13 (9.61)	8.1	0.73 (-0.07, 1.53)
Nieminen, 2016, 27152849	BDI	8	28	15.39 (11.92)	28	18.84 (11.66)	-3.5	-0.26 (-0.79, 0.27)
Shaw, 2014, 25049338	BDI	4-5	57	NR	41	NR	-4.1	NA

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, BDI = Beck Depression Inventory

Table F-64. CBT versus TAU for PTSD: Quality-of-life scores at end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Nieminen, 2016, 27152849	Quality of life inventory	8	28	1.42 (2.2)	28	1.56 (1.66)	-0.1	-0.07 (-0.59, 0.45)
Nieminen, 2016, 27152849	Eq-5D	8	28	0.73 (0.25)	28	0.75 (0.20)	-6.6	-0.09 (-0.61, 0.44)

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, Eq-5D = EuroQol-5 Dimensions

Table F-65. CBT versus TAU for PTSD: Symptoms of trauma at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Nieminen, 2016, 27152849	Impact of events	8	28	19.22 (14.29)	28	32.76 (16.73)	-13.5	-0.85 (-1.41, -0.31)
Shaw, 2014, 25049338	DTS	4-5	57	NR	41	NR	-7.4	NA
Shaw, 2014, 25049338	DTS	26	57	NR	38	NR	-5.9	NA

Abbreviations: PMID = PubMed ID, CBT = cognitive behavioral therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, DST = Davidson Trauma Scale

Table F-66. EMDR versus TAU for PTSD: Symptoms of trauma at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	EMDR N	EMDR Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Chiorino, 2020, 31805778	Impact of events	6	19	16.47 (13.26)	18	25.22 (11.52)	-8.8	-0.69 (-1.35, -0.02)
Chiorino, 2020, 31805778	Impact of events	12	19	9.58 (8.90)	18	17.56 (12.32)	-7.9	-0.73 (-1.39, -0.06)

Abbreviations: PMID = PubMed ID, EMDR = Eye Movement Desensitization and Reprocessing, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-67. EMDR versus TAU for PTSD: Mother-to-infant bonding at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	EMDR N	EMDR Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Chiorino, 2020, 31805778	Mother-to-Infant Bonding Scale	6	19	0.79 (1.08)	18	1.11 (1.23)	-0.3	-0.27 (-0.92, 0.38)
Chiorino, 2020, 31805778	Mother-to-Infant Bonding Scale	12	19	0.42 (0.77)	18	0.78 (1.40)	-0.4	-0.31 (-0.96, 0.34)

Abbreviations: PMID = PubMed ID, EMDR = Eye Movement Desensitization and Reprocessing, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-68. Psychoeducation versus TAU for PTSD: Symptoms of trauma at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	EDU N	EDU Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Upshur, 2016, 27480668	PTSS	8	79	2.68 (0.68)	59	2.69 (0.67)	-0.01	-0.02 (-0.35, 0.32)

Abbreviations: PMID = PubMed ID, EDU = Psychoeducation therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, PTSS = Post Traumatic Stress Scale

Table F-69. Psychoeducation versus TAU for PTSD: Social support at the end of treatment

Study, Year, PMID	Measure	Timepoint (Weeks)	EDU N	EDU Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95% CI)
Upshur, 2016, 27480668	Medical Outcomes Study Social Support Scale	8	119	17.76 (5.1)	135	17.27 (5.6)	0.5	0.09 (-0.16, 0.33)

Abbreviations: PMID = PubMed ID, EDU = Psychoeducation therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval

Table F-70. Counseling versus TAU for PTSD: Remission rate for depressive symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Gamble, 2005, 15725200	EPDS score >12	4-6	16/50 (32.0)	18/53 (34.0)	0.94 (-0.54, 1.64)
Gamble, 2005, 15725200	EPDS score >12	12	4/50 (8.0)	17/53 (32.1)	0.25 (0.09, 0.69) ^a

Abbreviations: PMID = PubMed ID, TAU=treatment as usual, RR = relative risk, CI = confidence interval, EPDS = Edinburgh Postnatal Depression Scale

^aStatistically significant difference.

Table F-71. Counseling versus TAU for PTSD: Remission rate for anxiety symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Gamble, 2005, 15725200	DASS-anxiety (>9)	12	1/50 (2.0)	6/53 (11.3)	0.18 (0.02, 1.42) ^a

Abbreviations: PMID = PubMed ID, TAU=treatment as usual, RR = relative risk, CI = confidence interval, DASS = Depression Anxiety Stress Scale – Anxiety Subscale

^aStatistically significant difference.

Table F-72. Counseling versus TAU for PTSD: Trauma symptoms at the end of treatment and follow-up

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling N	Counseling Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Gamble, 2005, 15725200	MINI-PTSD	4-6	50	4.81 (3.65)	53	5.45 (3.01)	0.7	-0.19 (-0.58, 0.20)
Gamble, 2005, 15725200	MINI-PTSD	12	50	2.54 (2.44)	53	3.83 (3.59)	-1.3	-0.42 (-0.81, -0.02) ^a

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, MINI-PTSD = Mini-International Neuropsychiatric Interview–Post-Traumatic Stress Disorder.

^aStatistically significant difference.

Table F-73. Counseling versus TAU for PTSD: Remission rate for PTSD symptoms

Study, Year, PMID	Measure	Timepoint (Weeks)	Counseling n/N Events (%)	TAU n/N Events (%)	RR (95% CI)
Gamble, 2005, 15725200	DSM-IV-R	4-6	17/50 (34.0)	16/53 (30.0)	1.13 (0.64, 1.98) ^a
Gamble, 2005, 15725200	DSM-IV-R	12	3/50 (6.0)	9/53 (17.0)	0.35 (0.10, 1.23) ^a

Abbreviations: PMID = PubMed ID, TAU = treatment as usual, RR = relative risk, CI = confidence interval, DSM-IV-R = The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised

^aStatistically significant difference.

Table F-74. CBT versus TAU for OCD: All outcomes

Study, Year, PMID	Measure	Timepoint (Weeks)	CBT N	CBT Mean (SD)	TAU N	TAU Mean (SD)	MD	SMD (95%CI)
Challacombe, 2017, 28137316	YBOCS	52	17	13.71 (8.95)	16	20.88 (6.34)	-7.7	-0.90 (-1.62, -0.18) ^a
	OCI	52	17	26.18 (23.80)	16	52.23 (30.96)	-26.06	-0.92 (-1.64, -0.20) ^a
	Ainsworth sensitivity (1–9)	52	16	5.41 (1.52)	16	5.25 (1.79)	-0.16	0.09 (-0.60, 0.79)

Abbreviations: PMID = PubMed ID, iCBT = intensive cognitive behavior therapy, TAU = treatment as usual, SD = standard deviation, MD = mean difference, SMD = standardized mean difference, CI = confidence interval, OCI = Obsessive Compulsive Inventory, YBOCS = Yale–Brown Obsessive–Compulsive Scale.

^aStatistically significant difference.