Abstract: Postpartum depression is a debilitating disorder that requires greater awareness and treatment. Depending on severity of symptoms, standard treatment calls for individual psychotherapy and medication. Although postpartum depression can lead to negative health outcomes for women and their offspring, numerous barriers prevent women from receiving appropriate care. A review of the literature shows that nontraditional modes of psychotherapy dominate recent studies, whereas data for other complementary options are severely lacking. Further research is needed to help identify cost-effective alternative therapies for treating postpartum depression. Combined with prevention and screening, treatment options that suit women’s varied situations and preferences must be explored to increase reception and adherence to treatment and, ultimately, to improve outcomes.
Keywords: alternative therapy | complementary and alternative medicine | literature review | postpartum depression

Postpartum depression is a serious concern that affects about 1 out of 9 women in the United States (Ko, Rockhill, Tong, Morrow, & Farr, 2017). The economic burden of depression in the United States is estimated at $210.5 billion and can be attributed to health care-, workplace-, and suicide-related costs (Greenberg, Fournier, Sisitsky, Pike, & Kessler, 2015). Maternal morbidities associated with postpartum depression include gestational diabetes, hypertension, blood transfusion, and preterm labor (Sundaram, Harman, & Cook, 2014). Postpartum depression also affects offspring and is associated with increased risk for intrauterine growth restriction, low birth weight, impaired cognitive development, and behavioral problems in infants and children (Conroy et al., 2012; Grote et al., 2010). In addition to the potentially major distress a woman may experience during a depression episode, she also remains at increased risk for recurrent depression episodes, during and outside of the peripartum period (World Health Organization, 2009).

Several factors contribute to health disparities for women suffering from postpartum depression. A woman who is unemployed, of low income, without college education, and unmarried is 11 times more likely than a woman without low socioeconomic status factors to experience depression at 3 months postpartum (Goyal, Gay, & Lee, 2010). Pregnant and postpartum women are less likely than nonpregnant women to receive mental health treatment (Vesga-López et al.,
Women at greatest risk for postpartum depression also have the lowest adherence to follow-up care (Knights, Salvatore, Simpkins, Hunter, & Khandelwal, 2016). Low-income women of color are particularly burdened because of less access to care (Howell et al., 2014). Treatment barriers include lack of transportation, time, and child care; insufficient health insurance coverage; and limited finances (Lara-Cinisomo, Wisner, Burns, & Chaves-Gnecco, 2014). Some cultural barriers to mental health care include language, preference for social support rather than formal care, and concerns that antidepressants are addictive (Lara-Cinisomo et al., 2014). Women without history of depression are also less likely to seek treatment for their current postpartum depression (Martinez, Vöhringer, & Rojas, 2016).

**Standard Treatment**

The American College of Obstetricians and Gynecologists (2015) recommends that women be screened by a clinician at least once during the perinatal period with a standardized tool, the most popular being the Edinburgh Postnatal Depression Scale (EPDS). An EPDS score of 13 or greater indicates high risk, although a cutoff score of 10 or greater or a positive response suggesting suicidal ideation is also reasonable for needing further evaluation (Knights et al., 2016). The Patient Health Questionnaire 9 is another common tool that takes less than 5 minutes to complete; a minimum score of 5 indicates mild depression (American College of Obstetricians and Gynecologists, 2015).

Ten to 20 weekly individual psychotherapy sessions is considered first-line treatment for people with mild to moderate depression, whereas moderate to severe depression calls for treatment with a selective serotonin reuptake inhibitor in combination with psychotherapy or alone for at
least 6 months (Bobo & Yawn, 2014). Cognitive behavioral therapy is the most common intervention for perinatal depression, although interpersonal therapy was found to be more effective in a meta-analysis (Sockol, Epperson, & Barber, 2011). In one depression study, behavioral activation was found to be as effective as cognitive behavioral therapy but less costly because of less training needed by mental health workers as opposed to psychologists (Richards et al., 2016). Group treatment has potential to be cost effective as well, but few group studies exist (Marrs, 2013).

Need for Alternative Therapies

Most women with postpartum depression prefer psychotherapy, plan to exclusively breastfeed, are reluctant to take medication, and would not pursue antidepressants because of concern for infant exposure (Battle, Salisbury, Schofield, & Ortiz-Hernandez, 2013; Freeman, Joffe, & Cohen, 2012). Interestingly, a systematic review has shown that behavior-based treatment is generally effective but that there are still inadequate data on antidepressants in postpartum women and their breastfed children (O’Connor, Rossom, Henninger, Groom, & Burda, 2016).

Given the many barriers to treatment, complementary and alternative medicine (CAM) is a compelling area of study. In a review of CAM for perinatal depression, Deligiannidis and Freeman (2014) recognized that despite growing use of CAM, the amount of well-designed studies is extremely limited. The authors were unable to incorporate any randomized controlled trials specifically on women with postpartum depression, but they did incorporate findings regarding depression, women, and/or antepartum women with omega-3 fatty acids, folate, S-adenosylmethionine, St. John’s wort, bright light therapy, exercise, massage, and acupuncture
Authors of a systematic review published in 2013 analyzed data from 2004 through 2011, found only six controlled trials involving 402 women, and concluded that data were insufficient to recommend massage, acupuncture, bright light therapy, or omega-3 fatty acid supplementation (Dennis & Dowswell, 2013).

**Literature Review**

**Purpose and Aims**

The aim of this article is to review what the latest research shows about the efficacy of nonstandard therapies in treating postpartum depression. CAM treatment in postpartum depression is the second most preferred option by women, but a major gap in the literature limits what choices could safely be recommended (Battle et al., 2013). Aversion to necessary treatment puts a woman at risk for inadequate treatment. If shown to be effective, alternative therapies have the potential to be practical options that are not only cost effective but potentially more appealing and convenient to women than traditional psychotherapy or pharmaceutical antidepressants. CAM methods and any psychotherapeutic interventions that vary from standard individual cognitive behavioral therapy or interpersonal therapy hold potential and are investigated here.

**Search Method**

A search was conducted in databases MEDLINE/PubMed, PsychINFO, and Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus for combinations of the search terms *postpartum depression, therapy, treatment, alternative*, and *complementary*. After filtering for peer-reviewed articles in English with human participants published from January 1, 2012,
through March 4, 2017, 603 studies were identified. Forty-five primary studies were reviewed for having inclusion criteria of a pretest and posttest quantitative measurement of depression in postpartum women using a standardized tool, detailed in Figure 1. Eighteen studies were further excluded for variables that limit their generalizability, yet they had promising outcomes worthy of further investigation.

Three of those 18 studies were excluded because of the use of inpatient treatment, which is used in extremely severe cases and is not in the scope of this review because of increased factors including multiple psychotropic medications. Of note, one inpatient study showed that heart rate variability biofeedback was effective in reducing anxiety symptoms with high rates of continued use (Beckham, Greene, & Meltzer-Brody, 2013).

Twelve of the excluded studies had no true control to compare the intervention. In one trial, a multivitamin improved depression significantly better than a calcium/vitamin D supplement (Paoletti et al., 2013). Several studies showed interventions that were equally as effective as the other treatment group in lowering depression scores: group problem-solving therapy versus amitriptyline, saffron versus fluoxetine, yoga versus a support group, and resistance versus flexibility training (Chibanda et al., 2014; Field, Diego, Delgado & Medina, 2013; Kashani et al., 2017; LeCheminant et al., 2014).

Three excluded studies did not randomize their participants. Of these, skin-to-skin contact with one’s infant ultimately did not significantly reduce depression compared with the control, but interpersonal therapy delivered via telephone by nurse-midwives, as well as rose and lavender
aromatherapy, did (Bigelow, Power, MacLellan-Peters, Alex, & McDonald, 2012; Conrad & Adams, 2012; Posmontier, Neugebauer, Stuart, Chittams, & Shaughnessy, 2016).

Results
Ultimately, 27 randomized controlled trials were found that involved 3,872 women in 10 different countries across all continents except for Africa and Antarctica, with the greatest number of studies in the United States (n = 9), followed by China (n = 6). Study characteristics are described in Table 1. Sample sizes ranged from 14 to 771, with a mean of 143 and median of 80 participants. Demographics such as age, race or ethnicity, postpartum time, socioeconomic status, and education level were not consistently reported. Analyses reporting effect size, significance level, and power were also not uniform across all articles. No studies analyzed cost effectiveness.

A multitude of factors influence the validity of these trials. All studies had varying starts of treatment postpartum, lengths of treatment, and posttreatment measurement of depression symptoms, in which outside events or time could influence improvement of depression by maturation or history effect. Two trials found significantly different baseline measures of treatment and control groups (Chen & Chen, 2015; Lee, Aycock, & Moloney, 2013). Depression symptoms were measured at varied times, from 0 through 19 months after treatment, and comparing the last measurement time of each study resulted in a mean of 3.9 months, median of 3 months, and mode of 6 months.
Inclusion and exclusion criteria varied widely among studies. Three studies screened for specific populations: Latina, Black or Latina, and White or Asian (Howell et al., 2012; Howell et al., 2014; Keller et al., 2014). Two studies included only primiparous women (Goodman, Prager, Goldstein, & Freeman, 2015; Shorey, Chan, Chong, & He, 2015). There was no consistency in depression measurement, which varied in screening tool and cutoff scores, but the most popular tool was the EPDS. Most trials screened for at least mild severity for inclusion, but some included women with any baseline depression score. Three studies focused on women with concurrent sleep disorders (Chang & Chen, 2016; Chen & Chen, 2015; Hou et al., 2014). Most women were excluded if they or their infants experienced any perinatal complications, whereas some specifically included women with preterm or low-birth-weight infants (Lee et al., 2013; Ravn et al., 2012). Studies inconsistently excluded women based on history of depression or concurrent treatments such as medications, supplements, and psychotherapy.

Most common were trials that tested a single nontraditional psychotherapy ($n = 14$), followed by those that tested a CAM intervention ($n = 8$) and mixed methods ($n = 5$). Almost all interventions had individual approaches, and two had group settings (Keller et al., 2014; Rabiei, Mazaheri, Masoudi, & Hasheminia, 2014).

**CAM Methods**

Only 7 out of the 27 articles focused solely on CAM interventions. These seven randomized controlled trials involving 396 women do not substantially change the inconclusiveness of CAM for postpartum depression. The largest of these studies, with 113 women in Italy, compared expressive writing about the birthing process and feelings versus nondescript writing (Blasio et
al., 2015). The intervention consisted of two writing sessions at least 10 minutes long, on average 4 hours apart, in the hospital on the third day postpartum, which resulted in significant improvement at follow-up 3 months later (Blasio et al., 2015).

Two studies in Taiwan focused on herbal teas and sleep improvement. Daily consumption of 1 cup of chamomile tea for 2 weeks significantly increased sleep quality and alleviated depression, whereas similar treatment with lavender tea showed improvement immediately after treatment but showed none at the 2-week follow-up (Chang & Chen, 2016; Chen & Chen, 2015).

One study in the United States consisting of gentle Vinyasa flow yoga sessions for 8 weeks resulted in significant reduction in depression (Buttner, Brock, O’Hara, & Stuart, 2015). The remaining studies, with some of the smallest sample sizes, showed no significance over control with their interventions. Two weekly sessions of electroacupuncture for 4 weeks in a sample size of 20 women in China did not show efficacy (Chung et al., 2012). Thirty minutes daily of bright light therapy for 3 weeks in a sample size of 30 women with low-birth-weight infants in a U.S. NICU did not improve depression symptoms (Lee et al., 2013). Three months of weekly oxytocin nasal spray in Italy were not effective for five women in a study of 16 participants total (Clarici et al., 2015).

**Nontraditional Psychotherapy and Support**

Fourteen articles tested single psychological or behavioral educational modalities for 2,294 women. Because individual, in-person cognitive behavioral therapy or interpersonal therapy is standard psychotherapy, alternate modes of delivery can be used to overcome treatment barriers.
Nine studies involved alternatives administered by home visit, telephone, online, or in groups. Three of the nine were based on cognitive behavioral therapy and effective in-home visits in the United States, telephone calls in China, and Internet modules in Canada (Ammerman et al., 2013; Ngai, Wong, Leung, Chau, & Chung, 2015; Pugh, Hadjistavropoulos, & Dirkse, 2016). Group education promoting self-awareness and social support significantly improved depression in Iranian women (Rabiei et al., 2014). Simple telephone support, for example, asking how a woman and her infant were, was also effective for Iranian women (Shamshiri Milani, Azargashb, Beyraghi, Defaie, & Asbaghi, 2015). On the other hand, three studies with in-home education about improving mother–infant interaction in the United States and Norway were not significantly effective (Goodman et al., 2015; Horowitz et al., 2013; Ravn et al., 2012). Authors of a study in the United States with two separate experimental groups, one with in-home doula services and the other with telephone support from women recovered from postpartum depression, found that neither intervention was significantly more effective than a control group (Gjerdingen, McGovern, Pratt, Johnson, & Crow, 2013).

Four studies involved in-person behavioral educational therapies. Two of these studies based on the common-sense model provided education to American mothers regarding depression and social needs but differed by population. One study focusing on White and Asian mothers found no significance, whereas another focusing on Black and Latina mothers had results that were significant within a month but were no longer effective after 3 months (Howell et al., 2012; Howell et al., 2014). Systemic family therapy, which incorporates family members to improve communication and social support, was shown to be effective in a study of 213 women in China, not only reducing depression symptoms but also increasing sleep quality (Hou et al., 2014).
Meanwhile, a smaller study of 21 women in the United Kingdom with a parenting and family focus did not find efficacy (Tsivos, Calam, Sanders, & Wittkowski, 2015).

The smallest study reviewed used a less conventional psychological therapy, repetitive transcranial magnetic stimulation, in a trial of 14 women implemented 5 days a week for 4 weeks that was found to be effective at follow-up after 2 weeks (Myczkowski et al., 2012).

**Mixed Methods of Treatment**

The remaining six studies used multiple approaches in their interventions. The largest trial in this review, with 771 women in China, found that a combination of mailed educational materials, telephone counseling, and in-person counseling was successful in treating depression (Jiang et al., 2014). Two studies that combined telephone and Internet modules based on behavioral action in the United Kingdom and cognitive behavioral therapy in Australia were significantly effective (Milgrom et al., 2016; O’Mahen et al., 2014). Also effective was an intervention that combined home visits with telephone therapy in Singapore (Shorey et al., 2015). One trial in the United Kingdom showed that in-person and telephone encouragement to exercise was effective (Daley et al., 2015). However, a study with Latina women in the United States that combined group walking sessions with group emotional and educational support showed no significant difference between that and the control group at follow-up (Keller et al., 2014).

**Summary**

Overall, all interventions resulted in improvement of depression symptoms over time in the experimental and control groups. Fifteen of the 27 randomized controlled trials showed clear
significant effect of the intervention over the control, 10 showed none, and 2 had mixed results among different follow-up points. Studies involving multiple interventions were more likely to be significantly effective than those of CAM methods or single psychotherapies.

There were no obvious trends related to factors such as country, race, or ethnicity for effective interventions. Considering the global scope of prevalence, cultural aspects such as preference for herbal remedies or social support are worthy of further examination in future research.

CAM trials tended to have smaller sample sizes. Expressive writing, chamomile or lavender tea, and yoga have shown promise, but no strong conclusions can be made because each of these interventions was tested only once. Further evidence is needed before CAM can be considered as a true alternative to current first-line standards for postpartum depression.

Most interventions involved a psychoeducational or behavioral component. All alternative deliveries of cognitive behavioral therapy were shown to be effective, but no studies provided direct comparisons between them. All studies involving the Internet or telephone showed efficacy in their interventions, highlighting that these modes of delivery for education and counseling can be valid solutions to increasing access to health care. Future research is necessary, including more randomized controlled trials with minimized bias for a wide variety of CAM, educational, behavioral, and psychosocial interventions, ideally comparing their efficacy against each other and their cost effectiveness versus standard treatment.

Implications for Practice
Clearly, further research for alternative therapies is needed to show their safety and efficacy as postpartum depression monotherapies or adjuncts. Their feasibility and appeal could mean increased treatment for women who face a multitude of challenges that prevent adequate care. Interventions must consider women’s unique preferences and cultural needs and be not only affordable but also accessible across diverse populations. Clinicians should carefully consider all kinds of treatment modalities, including pharmacologic options, for each woman’s individualized care plan.

Nurses have unique roles with opportunities to intervene at primary, secondary, and tertiary levels of prevention. Nurses may encounter women at risk for or suffering from postpartum depression in a variety of settings across all acuities, whether in the home, community, outpatient clinic, or hospital. Nurses, particularly those who work in maternity, obstetrics/gynecology, and pediatric settings, must be cognizant of risk factors for postpartum depression and be attuned to symptoms to be able to screen at any point of a woman’s or her infant’s health care visit.

Nurses advocate for women and their choices in health care. Nurses should ask a woman about her past mental health history, treatment preferences, and whether she is already participating in CAM, because it is not always obvious to her to disclose. It is crucial to be up to date with the literature regarding various CAM modalities and to distinguish which are relatively safe and favored, if at all. Health education includes the importance of treatment along with supportive methods for stress relief and health promotion. Being well-informed about common concerns and the latest therapies, especially with regard to lactation, will help women be assured that they have options in their care.
Understanding treatment barriers is key to implementing population-based care and effective case management. Nurses can collaborate to develop programs that help women receive appropriate care, whether it is for transportation, child care, or more culturally tailored approaches. Increased communication, by telephone or Internet, could help women adhere to therapy and feel emotionally supported at their convenience. Transitional care that ensures postpartum follow-up after discharge from the hospital should address not only breastfeeding issues but also a woman’s emotional well-being and whether she has a social support system. Increased awareness and screening alongside supportive systems that ensure diligent follow-up are all crucial components in comprehensive care.

**Conclusion**

Postpartum depression affects a woman’s functionality, increases her future risk of depression, and may be detrimental to the development of her children. Continued research in postpartum depression, including alternative therapies, is imperative for the progress of women’s mental health care. If enough studies are conducted with sufficient sample sizes, randomization, and control, alternative treatments could become established adjuncts or replacements for some forms of standard therapy. In the case of many women who have limited access and resources to follow recommended care, effective alternatives could help reduce health disparities and empower women to improve their quality of life.
Figure 1. Literature Selection Diagram

- 603 studies identified through database search
- 45 studies reviewed and fulfilled inclusion criteria
  - 12 excluded for no control
  - 3 excluded for inpatient subjects
  - 3 excluded for no randomization
- 27 included RCTs

Note. RCTs = randomized controlled trials.
<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention Type</th>
<th>Intervention Detail</th>
<th>Country</th>
<th>Sample Size</th>
<th>Time at Posttreatment</th>
<th>Measurement (months)</th>
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<td>Blasio et al. (2015)</td>
<td>CAM</td>
<td>Expressive writing</td>
<td>Italy</td>
<td>113</td>
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<td>CAM</td>
<td>Chamomile tea</td>
<td>China (Taiwan)</td>
<td>80</td>
<td>0, 0.5</td>
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<td>Chen &amp; Chen (2015)</td>
<td>CAM</td>
<td>Lavender tea</td>
<td>China (Taiwan)</td>
<td>80</td>
<td>0, 0.5</td>
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<td>Buttner, Brock, O’Hara, &amp; Stuart (2015)</td>
<td>CAM</td>
<td>Vinyasa yoga</td>
<td>United States</td>
<td>57</td>
<td>0</td>
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<td>Lee, Aycock, &amp; Maloney (2013)</td>
<td>CAM</td>
<td>Bright light therapy</td>
<td>United States</td>
<td>30</td>
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<td>Intervention Type</td>
<td>Interventions</td>
<td>Country</td>
<td>Sample Size</td>
<td>Length (weeks)</td>
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<tr>
<td>Chung et al.</td>
<td>CAM</td>
<td>Electroacupuncture</td>
<td>China</td>
<td>20</td>
<td>0, 1</td>
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<td>Clarici et al.</td>
<td>CAM</td>
<td>Oxytocin nasal spray</td>
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<td>16</td>
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<td>CBT</td>
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<td>0, 3</td>
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<td>Horowitz et al.</td>
<td>Home visit</td>
<td>Mother–infant interaction</td>
<td>United States</td>
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<td>2, 5</td>
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<td>Ravn et al.</td>
<td>Home visit</td>
<td>Mother–infant interaction</td>
<td>Norway</td>
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<td>3, 9</td>
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<tr>
<td>Goodman et al.</td>
<td>Home visit</td>
<td>Mother–infant interaction</td>
<td>United States</td>
<td>42</td>
<td>0, 3</td>
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<tr>
<td>Gjerdingen, McGovern, Pratt, Johnson, &amp; Crow (2013)</td>
<td>Home visit, telephone</td>
<td>In-home doula or telephone support</td>
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<td>39</td>
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<td>Ngai, Wong, Leung, Chau, &amp; Chung</td>
<td>Telephone</td>
<td>Telephone CBT</td>
<td>China (Hong Kong)</td>
<td>397</td>
<td>6</td>
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Shamshiri, Milani, Azargashb, Beyraghi, Defaie, & Asbaghi (2015) Telephone, Telephone lay support Iran 54 0°

Pugh, Hadjistayropulos, & Dirkse (2016) Internet, Internet CBT Canada 41 1°

Rabiei, Mazaheri, Masoudi, & Hasheminia (2014) Group, Group education and support Iran 133 2°

Howell et al. (2012) In-person, Common sense, educational, model United States 540 0.75°, 3, 6
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<th>Intervention</th>
<th>Country</th>
<th>N</th>
<th>Effect Sizes</th>
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<td>Common sense model</td>
<td>United States</td>
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<td>0.75, 3, 6</td>
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<td>Parenting and family focus</td>
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<td>Hou et al. (2014)</td>
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<td>Systemic family therapy</td>
<td>China</td>
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<td>0*, 1*, 7*, 13*, 19*</td>
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<td>Other</td>
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<td>Mixed</td>
<td>Group walking and behavior education</td>
<td>United States</td>
<td>93</td>
<td>3, 9</td>
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<td>Daley et al. (2015)</td>
<td>Mixed</td>
<td>In-person and telephone physical activity promotion</td>
<td>United Kingdom</td>
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<td>6*</td>
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<td>Jiang et al.</td>
<td>Mixed</td>
<td>In-person and</td>
<td>China</td>
<td>771</td>
<td>6*</td>
</tr>
<tr>
<td>Study</td>
<td>Treatment Type</td>
<td>Delivery Methods</td>
<td>Country</td>
<td>n</td>
<td>Follow-up (months)</td>
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<td>O’Mahen et al. (2014)</td>
<td>Mixed</td>
<td>Internet and telephone behavioral educational</td>
<td>United Kingdom</td>
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<td>Milgrom et al. (2016)</td>
<td>Mixed</td>
<td>Internet and telephone CBT</td>
<td>Australia</td>
<td>43</td>
<td>0*</td>
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<tr>
<td>Shorey, Chan, Chong, &amp; He (2015)</td>
<td>Mixed</td>
<td>Home visit and telephone psychoeducation based on self-efficacy</td>
<td>Singapore</td>
<td>122</td>
<td>1.5*, 3*</td>
</tr>
</tbody>
</table>

*Note.* Time at posttreatment measurement in months. CAM = complementary and alternative medicine; CBT = cognitive behavioral therapy.

* *p ≤ .05.*
References


Shorey, S., Chan, S. W., Chong, Y. S., & He, H. G. (2015). A randomized controlled trial of the effectiveness of a postnatal psychoeducation programme on self-efficacy, social support and


