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Principles of Supportive Psychotherapy for Perinatal Distress

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ABSTRACT

Although interpersonal psychotherapy and cognitive behavioral therapy have demonstrated efficacy in the treatment of perinatal distress, supportive psychotherapy has not been as widely studied by researchers. However, the principles of supportive psychotherapy are essential in the treatment of perinatal distress. The purpose of this article is to show that supportive psychotherapy is a plausible intervention that nurses and other maternity care providers can use with women who experience anxiety and depression in the perinatal period.

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More than four million live births occur annually in the United States (Martin, Hamilton, Osterman, Curtin, & Mathews, 2015). Estimates of the rate of postpartum depression in new mothers vary greatly and range from 5% to more than 25% (Gaynes et al., 2005). However, the true rate of emotional disturbance in the perinatal period is likely to be significantly greater when one considers the number of women who report subclinical but nevertheless distressing symptoms, experience emotional distress in the form of anxiety rather than depression, and experience perinatal loss or infertility. Researchers, advocates, and mothers recognize depression as the most common complication associated with childbirth (Grace, Evindar, & Stewart, 2003).

The emotional and psychological needs of women during the perinatal period have long gone unrecognized and undertreated (Vesga-Lopez, 2008). This is further complicated by the urgency of the great demands of the postpartum period. In their efforts to meet these demands, women's symptoms are often escalated, and paradoxically, during this time it is much more difficult for them to get treatment. If acute symptoms of distress are misunderstood or dismissed, women may retreat into silence, which reinforces the sense of helplessness and despair and prolongs suffering. Because they are significant public health concerns, heightened attention has recently been paid to depression during pregnancy and the postpartum period and anxiety during the transition to parenthood, that is, *perinatal distress*. In this article, we focus on a broader experience of perinatal distress, defined as depression or anxiety during pregnancy and/or during the first year postpartum. The American College of Obstetricians and Gynecologists (2015) addressed the importance of screening and proper treatment of maternal distress. The focus on the development and use of effective treatments for perinatal distress is the impetus for and the consequence of the recent screening recommendations put forth by the U.S. Preventive Services Task Force (2016). This increased awareness is indicative of the immediate need to develop and enhance current treatment options to improve efficacy and mitigate serious adverse outcomes.

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The significance of early intervention in the treatment of perinatal distress has been well established (Wisner, 2008). Most experts agree that the best treatment is effective and consistent with a woman's preferences and needs and minimizes harm to the fetus or infant. Efficacious pharmacologic treatments during the perinatal period are available, but women are often

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Supportive psychotherapy, often used by therapists of varying theoretical orientations, can improve adaptation and interpersonal functioning through encouragement, reassurance, attunement, and direction.

hesitant to take antidepressants because of concerns about fetal or infant exposure (Dennis & Chung-Lee, 2006), and some researchers noted that women reported preferences for psychotherapeutic interventions (Pearlstein et al., 2006; Turner, Sharp, Folkes, & Chew-Graham, 2008). An online search for perinatal distress and therapy yields multiple reviews of the efficacy of interpersonal psychotherapy (IPT) and cognitive behavioral therapy (CBT). However, supportive psychotherapy is the most commonly used treatment model (Misch, 2000), but limited data are available to show its effectiveness. Supportive psychotherapy is difficult to operationally define because this method integrates various psychotherapies, which leads to challenges in the articulation of its unique strategies. In general, engagement, encouragement, and support strategies are used in supportive psychotherapy to foster competency and ego strength situated within the therapeutic relationship. These elements of supportive psychotherapy are critical to incorporate into all therapeutic interventions and are worthy of research on the treatment of perinatal distress.

Evidence-Based Treatment for Perinatal Distress

Unquestionably, IPT and CBT dominate the landscape of evidence-based treatments for perinatal distress. IPT is a present-focused, time-limited therapy for major depression in which the connection between interpersonal problems and mood within the social context is emphasized (Weissman, Markowitz, & Klerman, 2000). Individuals and their therapists identify one or two interpersonal problem areas (e.g., role transitions, role disputes), and treatment is focused on the resolution of these difficulties. For women in the perinatal period, these problems are usually related to social support networks or impairment in the partner relationship (Stuart, 2012).

Many researchers have shown the efficacy of IPT. For example, in a landmark study, O'Hara, Stuart, Gorman, and Wenzel (2000) found that women who received IPT for postpartum depression improved to a greater degree than women assigned to a waiting list condition control group on interview-rated and self-reported depression and social and marital adjustment. IPT for postpartum depression was successfully adapted to group (Mulcahy, Reay, Wilkinson, & Owen, 2010; Reay et al., 2012) and partner-assisted (Brandon et al., 2012) formats. Spinelli and Endicott (2003) highlighted the efficacy of IPT for antenatal depression and found that it was more effective to reduce depression than parenting education. In another study, Spinelli and et al. (2013) showed that IPT was equally as effective as a form of parenting education to reduce symptoms of depression. In perhaps the best-known adaptation of IPT for perinatal depression, Grote et al. (2009) showed that culturally adapted IPT for low-income depressed pregnant women was effective during pregnancy and the first 6 months postpartum. IPT was more effective to reduce symptoms of depression than enhanced usual care (i.e., written education about depression, encouragement to seek treatment, and practical assistance such as flexible scheduling). In contrast, a paucity of research is available on the efficacy or effectiveness of IPT for perinatal anxiety, although investigators suggested that it is a viable option for the treatment of social anxiety, panic disorder, and posttraumatic stress disorder (Wenzel, Stuart, & Koleva, 2016).

CBT is another present-focused, time-limited treatment that was originally developed for depression, although it has been applied more broadly to mental health and adjustment problems than IPT. A basic tenet of CBT is that cognition mediates the association between situational stress and emotional and behavioral reactions, and as such, cognitive strategies are aimed to help individuals identify, evaluate, and Q2 modify or accept the presence of unhelpful thinking that exacerbates their emotional distress. As CBT has evolved during the past decades, a growing emphasis has been placed on behavioral interventions, such as behavioral activation for depression (i.e., the promotion of active engagement in meaningful activities in one's life) and exposure for anxiety (i.e., the systematic contact with a feared stimulus or situation). These associations among thinking, emotion, and behavior are attractive to the clinician, who can take a problem-solving stance that promotes tangible changes in a person's life, and to the individual, who usually experiences relief from the acquisition of coping skills in a manageable amount of time.

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