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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.

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

Supportive psychotherapy, often used by therapists of various 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 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).

Cognitive behavioral therapy 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 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.

Evidence to support the efficacy and effectiveness of CBT for perinatal distress is more inconsistent than the evidence on IPT, likely because of a lack of a consistent, agreed upon definition for CBT. For example, to our knowledge no investigators have evaluated the efficacy of case formulation–driven CBT, which is a hallmark feature in CBT that is adapted to individual clinical presentations (Wenzel et al., 2016). With regard to postpartum depression specifically, researchers found that CBT was at least as effective as psychodynamic psychotherapy (Cooper, Murray, Wilson, & Romaniuk, 2003) and selective serotonin reuptake inhibitors (e.g., fluoxetine; Appleby, Warner, Whitton, & Faragher, 1997). However, at least two groups of investigators raised the possibility that it was no more effective than nondirective counseling, which could be regarded as supportive psychotherapy (Cooper et al., 2003; Milgrom, Negri, Gemmill, McNeil, & Martin, 2005).

In contrast, two groups of researchers examined the use of CBT to treat antenatal depression and showed that it significantly outperformed usual care in the reduction of self-reported symptoms of depression (Burns et al., 2012; Hayden et al., 2012). Moreover, CBT has the potential to be especially useful for the treatment of perinatal anxiety; in preliminary findings, researchers found that exposure-based CBT significantly reduced blood/injury/injection fears in pregnant women with these specific phobias (Lilliecreutz, Joseffson, & Sydsjö, 2010) and prevented the onset of obsessive compulsive disorder in new mothers (Timpano, Abramowitz, Mahaffey, Mitchell, & Schmidt, 2011). CBT is generally regarded as an effective treatment for perinatal distress and for mental health problems in the general population (Butler, Chapman, Forman, & Beck, 2006).

Supportive Psychotherapy

Although its roots are in psychodynamic, insight-oriented traditions, supportive psychotherapy is currently focused more on the effect of symptoms on an individual; strategies include engagement, encouragement, and support. The here-and-now focus of supportive psychotherapy seems to resonate for individuals in acute distress. Researchers validated that most psychotherapists, regardless of their therapeutic orientation, rely on supportive techniques as core components of their work (Brenner, 2012; Harari, 2014). Above all, the collaboration between the therapist and individual is fundamental.

Nurses are optimally positioned to initiate dialog with women in distress during the perinatal period to maximize symptom relief and access to treatment.

Amid the many psychotherapeutic interventions and the preponderance of evidence in favor of structured, time-limited approaches such as IPT and CBT, the strength of supportive psychotherapy as a treatment model for perinatal distress may be overlooked. Without a clear definition and description of the process of supportive psychotherapy, its measurement and relationship to outcomes become difficult to determine.

For instance, in Wallerstein's (1989) longitudinal Psychotherapy Research Project of the Menninger Foundation, supportive psychotherapeutic components were difficult, if not impossible, to disentangle from distinctive approaches such as psychoanalysis and expressive psychoanalytic psychotherapy. Moreover, it was observed that supportive psychotherapy components constituted significant mechanisms of change regardless of whether the treatment was intended to be supportive or was geared toward traditional psychoanalysis or expressive psychoanalytic psychotherapy (Wallerstein, 1989).

Available evidence on the use of supportive psychotherapy in the treatment of perinatal distress is sparse. Some supportive approaches for perinatal distress, such as telephone-based peer support (Dennis, 2003), counseling by public health nurses (Holden, Sagovsky, & Cox, 1989), and support from partners (Misri, Kostaras, Fox, & Kostaras, 2000), have been shown to be effective to reduce symptoms associated with postpartum depression. In some comparative studies, researchers used supportive psychotherapy, or nondirective counseling, as a control condition with which more active treatments such as CBT were compared. In some of these comparison studies, researchers found that less active approaches were as effective as active treatments (Cooper et al., 2003; Milgrom et al., 2005). Perhaps the most significant and systematic work on supportive psychotherapy is a manual in which Freeman (2004) emphasized the central elements of supportive therapy with women in the perinatal period (e.g., working alliance, empathic resonance, and mutual affirmation) and the therapeutic alliance within a structured framework of six sessions over 8 weeks of participation. Freeman and colleagues

studied the implementation of the structured intervention based on the manual and found that the more supportive psychotherapy sessions women attended, the more their scores on an interview-rated depression scale were reduced (Freeman & Davis, 2010; Freeman et al., 2008).

Influence of Early Psychoanalysts and the Art of Holding Framework

Clinicians have reflected on the importance of the therapeutic relationship for decades. In the 1960s, Carl Rogers and Donald Winnicott were prominent thought leaders in psychoanalysis and the therapeutic relationship. Rogers (1961) highlighted the significance of the therapeutic relationship long before others began to recognize its value; he posited that the relationship between an individual and his or her therapist could be used as a primary instrument of change and argued that when a person felt accepted and cared for, personal growth became possible (Rogers, 1961). When Rogers began his research into the helping relationship, he noted two prominent themes: the first theme was focused on a therapist's attitudes, such as warmth, acceptance, positive regard, trustworthiness, and genuineness; the second theme indicated that an individual's perception of the therapist's attitudes and feelings had a significant effect on outcomes (Rogers, 1961). His patient-centered perspective continues to be important in contemporary psychotherapy as clinicians seek to maximize the unrealized resources inherent within the therapeutic relationship.

A renowned pediatrician and psychoanalyst, Donald Winnicott also revolutionized the world of psychotherapy with his astute attention to the transformative power of the therapeutic relationship. Perhaps one of his most enduring contributions was his concept of the *holding environment*, that is, a safe, secure space in which independence and optimal psychological development are facilitated (Winnicott, 1960). To incorporate the insight of Winnicott into a framework of therapy for women in distress during the perinatal period is a natural progression:

> Not unlike holding the infant with primal needs and impulses, we [therapists] stay attuned to the new mother's most primitive emotions, what is scaring her, what is immobilizing her, and what is so deep that she can't even put it into words. When we hold on to and tolerate these emotions, managing them without judgment, and without feeling as overwhelmed as she does, we can succeed in containing them. In doing so, we effectively care for her, which is a prerequisite for postpartum healing. (Kleiman, 2009, p. 42)

Art of Holding Framework for Women in the Perinatal Period

In *The Art of Holding in Therapy* (Kleiman, 2017), elements of supportive psychotherapy were redefined within the perinatal framework to maximize therapeutic sessions:

> Holding, within the context of therapeutic work with postpartum women, is defined as a loss-informed, strength-based approach which enables the therapist to contain high levels of distress and do so in a way which cultivates the early stages of connectedness. This attempt to contain her symptoms of agitation and despair is accomplished despite the innate pull she feels to repair this herself in order to preserve what she perceives as her dwindling sense of control. (Kleiman, 2017, p. 4)

Using this conceptual framework, six holding points were established as a primary supportive psychotherapy intervention for perinatal distress. The use of holding points and the incorporation of the loss-informed perspective (e.g., loss of previous self, loss of control, loss of self-identity, loss of sleep, etc.) allow for the identification of grief reactions that many women experience (typically manifested as resistance, denial, protest, or withdrawal) as they struggle to redefine and find meaning for their postpartum experiences. The six holding points include *Grounding, Current State, Expert, Design, Presence,* and *Safeguarding*. Clinical experience suggests that the application and timing of each point is contingent on sound clinical interpretation and judgment. Within a single interaction with a woman in therapy, a therapist is likely to use or consider all six points simultaneously. They are not mutually exclusive. The ability to apply these holding points within each therapeutic moment differentiates a therapist who specializes in the treatment of perinatal emotional illness from a therapist without specialized training.

Although specific psychotherapeutic recommendations and skill-building techniques have been documented elsewhere (Kleiman, 2017), in this

Table 1: Holding Points and Nursing Applications for the Use of Supportive Psychotherapy in Women With Perinatal Distress

Holding Point	Key Nursing Application
Grounding	Reassurance, nurturing, stabilization of symptoms
Current State	Assessment of symptoms with regard to defenses and potential resistance, reflective listening
Expert	Calm control, understanding of current state, knowledge, acceptance, tolerance
Design	Resources, treatment plan, referral, directives
Presence	Reliable and enduring regard for symptoms and defenses, interpersonal attunement
Safeguarding	Consistent, ongoing monitoring of well-being, reinforcement of strengths, cultivating resilience

model, a strategic frame of reference for nurses and other maternity care providers is offered. It has been suggested that basic principles of supportive psychotherapy should be considered an integral part of any provider–patient relationship within a medical practice (Harari, 2014). During the perinatal period, women in distress need help urgently. Conceptualization of supportive psychotherapy in terms that are efficient and teachable is paramount. Although principles of the holding approach to perinatal distress were conceived in an effort to provide a counseling framework for psychotherapists, nurses can easily adapt these principles to facilitate the physical and emotional well-being of a new mother. The adaption of supportive psychotherapeutic techniques can enhance the nurse–patient relationship and may lead to the initiation of critical nurse–patient dialogs.

Nurses have repeated contact with women in the perinatal period and are often able to determine whether they require additional support or resources. In fact, some researchers found that nurses who specialized in maternal and child health and received appropriate training were aptly suited to identify and treat perinatal depression (Segre, O'Hara, Arndt, & Beck, 2010). Thus, holding points can and should be integrated into perinatal nursing care to ensure and maximize maternal mental health. The six holding points and their key clinical applications are summarized in Table 1.

Grounding

Within the context of psychotherapy for perinatal distress, *Grounding* refers to a therapeutic action taken in response to a person's symptomatic expression of loss. Whether this distress is displayed as panic, anger, irritability, sadness, guilt, or any other manifestation of depression, *Grounding* refers to specific therapeutic endeavors that convey the early message that a woman has taken this first step and she can expect to feel better. Grounding techniques are used frequently in therapy with many types of people to reduce or diffuse excessive emotional energy. For instance, as a grounded wire secures physical safety, grounding in therapy secures emotional safety and helps a woman feel less agitated and more secure. Often, grounding exercises are used to help the woman remain present and less distracted by symptoms. At other times, grounding techniques can simply be the use of the right words, the right tone, and the right gesture, to contain symptoms.

Grounding, with reassurance and specific reference to a woman's decision to prioritize self-care through the engagement in therapy, conveys the early message that a professional can help her regain a sense of control and that she will not have to endure alone. This message may be delivered by a therapist who can provide professional clarity and access to treatment or by a nurse who lets the woman know there is a name for what she is feeling and that help is available. In this way, *Grounding* generates early stages of hope. When treating women in the perinatal period with depression and anxiety, hope is a legitimate intervention and can be carried out by any health care provider in the position to respond to early expressions of distress. Nurses can ground initial distress by identifying it, naming it, and offering reassurance that relief is possible.

Current State

Current State requires a rapid evaluation of a woman's status, which includes determination of physical safety. In therapy, a thorough history is taken to evaluate the comprehensive clinical

An infrastructure for appropriate responses to symptoms of perinatal distress should be integrated into nursing care to ensure maternal mental health.

picture. Assessment includes a determination of level of distress and how much it interferes with the ability to function. Nurse-initiated depression screening and the implementation of treatment protocols for women in the perinatal period are necessary clinical skills (Segre et al., 2010). Whether this refers to a standard assessment protocol or simply to the attentive and intuitive response from a professional nurse who is tuned in to the unique needs of these women, sensitivity and responsiveness to the subtleties during this vulnerable time are essential. Assessment of current emotional and mental states of women in the perinatal period, particularly those in acute distress, is a crucial task for nurses. Access to proper training and a system for mental health referral in this area must be a priority.

Expert

The therapist's role as *Expert* helps quiet a woman's distress with the introduction of the thought that everything will be okay and that the therapist knows how to facilitate and work toward that desired outcome. The role of *Expert* must be achieved with precision and attention to each woman and her specific symptoms to establish trust and minimize misinterpretations. Taking on the role of the *Expert* is done with gentle but unwavering confidence and a belief in one's ability to help a woman begin to heal. It is expressed through voice, tone, words, eye contact, posture, energy, and intention.

Nurses and other maternity care providers have the advantage of permissible touch, which enables a level of contact that can facilitate intimacy and promote healthy outcomes. The nurse is routinely an expert in maternal well-being and may be perceived as an authority upon which the woman can rely. Professional expertise, whether psychotherapeutic or nursing, is often viewed as a relief mechanism to a woman who feels as if she is sinking away from her very self. The claim of expertise is translated into *I can help you*. This statement, when uttered with firm and gentle confidence, can be a lifeline to a woman in distress.

Design

The *Design* point incorporates the motivation, resources, and structure to develop an outline for symptom relief and the beginning of a treatment plan. This plan includes a woman's expectations and personal preferences as well as her therapist's recommendations. Areas of strength and resilience should be identified and used. At the early stages of connection, perhaps even more important than the treatment itself is the prospect of a plan and the message of hope.

Nurses and other maternity care providers should focus on accessing and delivering appropriate resources that are available to support a woman whether or not symptoms are present. Researchers found evidence that early detection of depression symptoms augments recovery, which supports the key role nurses play in assessing and counseling women about the symptoms of perinatal anxiety and depression (Horowitz & Goodman, 2005). Moreover, researchers identified the importance of recognizing women at risk in obstetric, pediatric, and family practice settings (Alhusen & Alvarez, 2016). When they reference resources on behalf of women in distress, nurses should never underestimate their own value as resources of intervention and support.

Presence

The ability to establish and sustain a meaningful connection with a person is initially and continuously challenging for a therapist, but this connection is the psychotherapist's greatest tool. When a therapist successfully embodies kindness and authenticity, the woman begins to engage with the process and joins with the therapist. To remain present in the face of screaming symptoms requires skill and precise practice. During this time, the therapist sits with suffering, a great level of distress is tolerated, and the woman begins to believe she will not always feel this way.

An advantage for nurses is that their presence is not interpreted as a failure to cope; rather, nurses are viewed as natural components in the medical setting. Nurse-delivered information and support are likely to be accepted by women who experience symptoms of anxiety and depression, which allows nurses to effectively encourage optimal self-care, peer support, or treatment when indicated. A nurse's ability to remain present and undeterred regardless of distracting symptoms is a fundamental holding posture.

Safeguarding

Safeguarding, the final holding point, is implemented when a woman expresses what she

wants, how she got here, what she is afraid of, what she needs, how she is most vulnerable, and how the therapist can help. A therapist never loses sight of how exposed the woman may continue to feel. The therapeutic space continues to be used to protect her, which means the therapist is always on the lookout to predict and prevent relapse or breakthrough symptoms.

Similarly, nurses and other maternity care providers must respond to the needs of women in distress through alert observation and monitoring of symptoms. Finding and reinforcing areas of personal strength will serve to protect women from the onslaught of overwhelming symptoms. Ongoing and gentle communication of potential or expressed symptoms will provide reassurance and significant relief to women who may be reluctant to expose the depth of their suffering. Monitoring for severe symptoms that can present in the first few days postpartum is a top priority.

Conclusion

The elements of holding are essential in working with women with distress in the perinatal period. The ability to hold a woman and to simultaneously ground her, attend to her current state, embody the expert, prepare and execute a plan, remain present, and ensure her safety are key to helping her find symptom relief and begin to heal. Holding a woman in distress with this model helps identify primary areas of vulnerability and access and increases the likelihood that she will engage in treatment, if indicated. If a woman in distress does not feel understood or sufficiently cared for while in the care of a health care professional, her symptoms could worsen and become more difficult to treat.

Despite the widespread practice of supportive psychotherapy with women in the perinatal period, the lack of evidence in the literature to support this approach is glaring. As the national conversation on perinatal depression and anxiety disorders continues to promote greater awareness and acceptance in the medical community, controlled studies to evaluate the efficacy of supportive psychotherapy are warranted. Descriptions of supportive therapy are often vague, and this lack of clarity potentially undermines the value of the therapeutic approach and may interfere with professional or consumer compliance. Ideally, future research should be guided by the rationale that subjectively, in the perinatal period, women report significant and observable improvement as the result of supportive psychotherapy.

Clinical researchers are strongly urged to conduct research on (a) the efficacy of supportive psychotherapy in its own right and relative to evidence-based approaches such as IPT and CBT, (b) the mechanisms of change associated with supportive psychotherapy, (c) the components of supportive psychotherapy that are present (and facilitate change) in evidence-based treatments like IPT and CBT, and (d) the effective application of supportive psychotherapy principles by related health care professionals, such as nurses. As a loss-informed, resiliency-focused approach to healing, the use of holding practices enables supportive psychotherapists and nurses to organize their thinking in response to the urgency of a perinatal woman in distress. Although intuition and passion might be driving forces behind this work, holding techniques require constant scrutiny, not unlike any other psychotherapeutic skill. In the nursing profession, predisposition and aptitude for caring have limited bearing on the ultimate influence a professional relationship can have. The delicate and most central balance between one's good instincts and each next action coincides with the acuteness of the perinatal context. Holding a perinatal woman in distress is the appropriate and responsible intervention for any health care provider within the vicinity of her symptoms. As far as the women are concerned, they want simply to feel better and to return to their previous levels of functioning. The application of holding points, regardless of a therapist's theoretical orientation or a nurse's experience with specific counseling techniques, represents one important gateway to healing.

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