

# The process of change in psychotherapy with a pregnant patient following perinatal losses: An analysis of a case study

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## Abstract

**Aim:** Despite research suggesting increased anxiety and depressive symptoms after a perinatal loss and during future pregnancies, little knowledge exists to guide clinicians treating pregnant women after perinatal loss. This case study explores processes that facilitated therapeutic change for a pregnant patient with major depressive disorder (MDD) and posttraumatic stress disorder after perinatal losses.

**Method:** The study integrated quantitative and narrative analyses in a single case derived from the pilot phase of a randomized controlled trial on supportive-expressive therapy for MDD.

**Results:** The quantitative and narrative analyses suggest that an improvement in maladaptive interpersonal patterns toward the therapist, in the form of attachment avoidance, made it possible to form a strong alliance, which in turn led to a successful outcome.

**Conclusions:** The findings highlight the importance of improving maladaptive interpersonal patterns as a prerequisite to enable patients after pregnancy losses to develop and maintain a corrective therapeutic experience.

\*These authors contributed equally to this study.

**KEYWORDS**

alliance, interpersonal patterns, major depressive disorder, perinatal loss, psychotherapy, supportive-expressive therapy

## 1 | INTRODUCTION

Losing an unborn child is a traumatic event for expecting parents. The experience of looking forward to a life that turns into death creates a complex, and for some, an unbearable situation. Perinatal loss is a broad term that includes losses during pregnancy itself and up to approximately 1 month after birth. Although the conditions differ in the time of loss and contributing circumstances, they are all unexpected and traumatic. A perinatal loss has a relatively high incidence. International rates show that 12 to 24% of detected pregnancies fail to result in the birth of a living infant, across all cultural and socioeconomic groups (Diamond & Diamond, 2016; Keren, 2010).

There is a wide agreement that pregnancy loss can lead to painful and lasting grief and to a wide variety of other psychological and social consequences. Studies estimate that approximately 30% of pregnancy losses are followed by significant emotional reactions, often by diagnosable disorders, including depressive disorders, anxiety disorders such as posttraumatic stress disorder (PTSD), or substance abuse (Diamond & Diamond, 2016; Markin, 2017).

The majority of women who suffer perinatal loss become pregnant again, with estimates ranging between 50 to 85%. There are demonstrable effects of pregnancy loss on emotional states during subsequent pregnancies and on the attachment to subsequent children (Diamond & Diamond, 2016). After pregnancy loss, pregnant women often re-experience the traumatic event of the loss, avoid what is associated with the trauma, and experience impaired functioning and increased arousal. They are more fearful of childbirth and at increased risk of postpartum depression (Côté-Arsenault & O'Leary, 2015). All these adverse effects are especially present following multiple losses (Markin, 2017).

In addition to symptoms of anxiety and depression, important interpersonal difficulties have been documented in the literature on pregnant women who had the perinatal loss in the past. After the perinatal loss, many women report a lack of social support and severe interpersonal difficulties as a result of the loss, including permanent loss of relationship with friends, colleagues, or extended family members. Lack of recognition and support of the loss is also expressed at the broader, societal level, for example, in the expectation of others to move on rapidly to a subsequent pregnancy. This may cause these women to feel isolated, hold back their emotions and thoughts, and act with withdrawal and avoidance (Keren, 2010; Markin, 2017; Markin & Zilcha-Mano, 2018).

Research on how to guide clinicians working with this population is still lacking, despite the great need for it (Keren, 2010). A recent special section in the journal *Psychotherapy* on psychotherapy for patients with pregnancy loss highlights this lack and the need for up-to-date research (Markin, 2017). Given the severe interpersonal difficulties women often experience following perinatal loss, it has been suggested that one type of treatment that can benefit these patients is psychodynamic psychotherapy focused on the interpersonal relationships (Leon, 1987). Psychodynamic psychotherapy treatments operate on a continuum of supportive-expressive interventions (Leichsenring & Schauenburg, 2014). It is important to examine whether and in what ways each of the two ends of the continuum fits the needs of this population.

The expressive end of the continuum includes interpretive interventions aimed at assisting patients in gaining insight about repetitive interpersonal patterns sustaining their problems (Leichsenring & Leibing, 2007). The expressive approach is intended to help patients comprehend how internal representations that were formed based on past experiences influence current and future relationships. By gaining such insight, patients can work with the therapist on changing dysfunctional patterns of interpersonal relationships, for example, avoiding certain behaviors and expanding their perceptions and responses (Leichsenring & Schauenburg, 2014).

The Core Conflictual Relationship Theme (CCRT) framework (Luborsky & Crits-Christoph, 1998) has been developed and abundantly used to create insight and make changes in the patient's interpersonal patterns. The CCRT is used to formulate a clinical psychodynamic conceptualization for internal relationship representations, based on three core components: the patient's main wish (W) in an interpersonal relationship; an actual or anticipated subjective response from the other (RO) in relation to the patient's wish; and a subsequent response, emotional and behavioral, from the self (RS) regarding the response of the other. Using the CCRT formulations, patients and therapists can work together on changing patients' central relationship patterns to expand their perceptions of others' reactions to them (RO) and their responses (RS), thereby actualizing their interpersonal wish (Book, 1998).

This intervention may be specifically suitable for the population of pregnant women after multiple perinatal losses. First, these women may face interpersonal difficulties considering a potential RO of lack of recognition and support from their environment. Second, they may face interpersonal difficulties because of their potentially withdrawn and avoidance RS. Finally, they often have a wish (W) to be validated, cared for, and supported in their distress. Therefore, in therapy, the work with pregnant women who have experienced a perinatal loss may focus on achieving insight into their interpersonal difficulties as a means of expanding their RO and RS, thereby actualizing their interpersonal wish.

The supportive end of the continuum includes interventions aimed at strengthening patients' abilities that are temporarily inaccessible to them because of the acute stress caused by the traumatic event of perinatal loss (Diamond & Diamond, 2016; Leichsenring & Leibing, 2007). Supportive techniques aim to strengthen the patient's ego, enhance self-esteem, and promote exploration of emotions while facilitating the use of higher-level defenses. According to Book (1998), supportive techniques in supportive-expressive therapy include defining the therapeutic frame, offering empathic comments, noting gains, and demonstrating genuine interest and respect. With pregnant patients who have experienced multiple perinatal losses, the therapist may normalize and validate their reactions and describe them as natural responses to the death of a baby to whom they were attached (Diamond & Diamond, 2016).

An important aim of supportive treatment based on the CCRT perspective is to actualize the patient's interpersonal wish in treatment (Leibovich, Nof, Auerbach-Barber, & Zilcha-Mano, 2018). With women who have experienced multiple perinatal losses, this may include actualizing their wish for acceptance and support, especially with regard to the traumatic events, without rejecting or reducing their pain. The patient may undergo a corrective experience with the therapist—that is, “one in which a person comes to understand or experience effectively an event or relationship in a different and unexpected way” (Castonguay & Hill, 2012, p. 5). The corrective experience, facilitated by a skilled therapist, may feel like a breakthrough for the patient. The patient has an opportunity to engage in new behaviors, adopt healthier ways of relating to others, and develop a more positive view of herself. The patient also has the opportunity to feel previously unacceptable feelings and actualize an unmet interpersonal wish.

We suggest that actualizing one's wish and creating corrective experiences in the relationship with the therapist may be especially therapeutic for the population of pregnant women after multiple perinatal losses. The process of grieving is essential in clinical work with patients who have experienced pregnancy loss. This includes the experience of a significant other who listens to the patient's experiences of the traumatic events, validates and normalizes her experiences, and provides support without rejecting and reducing her pain, perhaps contrary to current reactions from people in the patient's life (Diamond & Diamond, 2016). This can serve as a corrective experience (Castonguay & Hill, 2012) that actualizes the patient's wish in the treatment room (Book, 1998), making it possible for her to be in touch with her feelings of loss, and therefore to work them through in treatment.

The two ends of the supportive-expressive continuum may be regarded as two models that are based on distinct roles of the therapeutic alliance (Zilcha-Mano, 2017). According to the expressive approach, the main mechanism of change is insight. The interpretations based on the CCRT result in gaining insight, which in turn results in changing maladaptive patterns of relating to others. These changes manifest also in a better alliance with

the therapist. Thus, in the expressive model, the gains in the alliance are the result of expressive work focusing on creating changes in maladaptive repetitive patterns of relating to others. According to the supportive approach, the main mechanism of change is the alliance. Through the corrective experience with the therapist, changes can take place in the patient's repetitive patterns of relating to others. Whereas in the expressive approach, the change in maladaptive patterns is the cause of improvement in the alliance, in the supportive approach it is the result of such improvement.

Current psychodynamic approaches for perinatal loss appear to focus more on the supportive techniques of validation, normalization, and regulation rather than on expressive techniques (Markin, 2017). The present study explores the potential role of each of these two approaches in the treatment of a pregnant woman who suffered perinatal losses to explore the potential contribution of each approach for this population of patients. In the absence of empirical knowledge, clinical case studies may be the most productive way of identifying the techniques that are effective in treating this population. In this case study, we explored how the expressive approach (focusing on changing the patient's maladaptive insecure attachment style) and the supportive approach (focusing on providing a corrective experience for the patient with the therapist) contributed to the process of therapeutic change. We have integrated narrative and quantitative analyses in our investigation.

Using quantitative approaches, we compared two potential mediation models, an expressive and a supportive model of therapeutic change: The expressive model stresses that expressive techniques enable changes in maladaptive interpersonal patterns (attachment avoidance in our case, given that this pattern was found to be prevalent in this population, as described above) that predict changes in the alliance, which in turn predict treatment outcome. The supportive model stresses that the implementation of supportive techniques results in gains in the alliance, through the actualization of an unmet interpersonal wish and the creation of a corrective experience. This process may then result in changes in maladaptive interpersonal patterns (attachment avoidance), which in turn may affect treatment outcome. Narrative analysis was used to explore the details of the process of therapeutic change. The patient received supportive expressive (SE) therapy as part of the pilot phase of therapists' training for a randomized controlled trial (RCT) on SE therapy for major depressive disorder (MDD).

## 2 | METHOD

### 2.1 | The patient and the presenting problem

The patient was a married woman in her forties, who at the beginning of treatment started the second trimester of her pregnancy. The present pregnancy after a period of 10 years in which she had been trying to give birth, underwent fertility treatments and experienced multiple perinatal losses, one in the advanced stages of pregnancy. She worked in a highly demanding job and reported that she had been feeling depressed for several years. She experienced difficulties with sleeping, interpersonal and professional functioning, feelings of guilt, hopelessness, and worthlessness. She sought therapy because of depression.

### 2.2 | The therapist

An experienced female clinical psychologist in her thirties received comprehensive training SE therapy, a manualized psychodynamic treatment (Luborsky, 1984), as part of the pilot phase of the RCT. The training included 15 hr of guided reading, followed by an intensive, 20-hr training workshop in supportive and expressive techniques. The training included formal teaching and role-playing, using a variety of SE techniques. During the pilot phase and after the start of the research, all the therapists received weekly group supervision from two supervisors, and weekly individual supervision from one of the supervisors. Individual and group supervisions made extensive use of videotaped sessions for feedback.

## 2.3 | Treatment

The treatment was SE therapy (SE; Luborsky, 1984), a time-limited psychodynamic therapy adapted for depression. SE therapy is based on a clinical case conceptualization according to the CCRT method (Luborsky & Crits-Christoph, 1998). The treatment was based on both supportive and expressive approaches. The expressive approach was based on identifying and working through the patient's CCRT to assist her in recognizing her internal representations and maladaptive relationship patterns and working through them. The supportive approach was based on providing the patient with a corrective experience with the therapist and the actualization of her unmet interpersonal wish. The active phase of treatment lasted 16 weeks, and therapy sessions were provided weekly (for additional details, see Zilcha-Mano, Dolev, Leibovich, & Barber, 2018).

## 2.4 | Measures

*Experiences in Close Relationships scale—short form* (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007): a 12-item self-report questionnaire, used to assess attachment orientation toward the therapist. Internal reliability for the present study was 0.52 for avoidance and 0.64 for anxiety.

*Working Alliance Inventory—short form* (WAI; Horvath & Greenberg, 1989): a 12-item patient-rated version of the WAI, used to assess the quality of the therapeutic alliance. Internal reliability for the present study was 0.90.

*Beck Depression Inventory* (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961): a 21-item self-reported inventory, used to assess the severity of depression. The internal reliability of the present study was 0.85.

*Hamilton Rating Scale for Depression* (HRSD; Hamilton, 1960): a 17-item clinically administered measure, used to assess the severity of depression. Seven of the sessions were coded by two independent raters to compute reliability. Inter-judge reliability for the present study was 0.93.

*MINI International Neuropsychiatric Interview* (Sheehan et al., 1998): a relatively short but psychometrically sound structured interview, used to assess 17 common Axis I disorders with 154 items. It was used to ascertain MDD diagnosis, assess comorbid conditions, and identify conditions that merited exclusion from this study.

*The Structured Interview for DSM-IV Personality Disorders—Hebrew version* (SIDP-IV; Pfohl, Blum, & Zimmerman, 1997): a 79-item semi-structured diagnostic interview for the assessment of all DSM-IV Axis II diagnoses, used to assess personality disorders.

## 2.5 | Procedure

This study was conducted with the approval of the relevant ethics committee. The patient and therapist signed consent forms, agreeing to videotaping of their sessions and using the measures collected for the research. To protect the confidentiality of patient and therapist in the after clinical vignettes, we disguised the background details. The participants gave both written and oral consent in advance. The patient answered an ad published at a university, offering short-term therapy for depression. After a prescreening call for an initial assessment of exclusion criteria, the participant underwent two intake meetings to further assess inclusion and exclusion criteria and to complete the measures before treatment. She met the criteria for MDD according to the MINI, as well as other inclusion criteria, including a score of 18 and 19 on the HRSD-17 at the two intake sessions. The patient completed the HRSD and BDI at intake and before each session and completed the WAI and ECR-S after each session throughout the study.

## 2.6 | Narrative and quantitative analyses

### 2.6.1 | Narrative analysis

Narrative analyses of content (Braun & Clarke, 2006) consisted of reviewing the videotaped therapy sessions and exploring the interpersonal processes occurring throughout treatment between the patient and therapist; this was done

independently by two researchers. We systematically went through all the sessions and identified interventions that seemed to be representative of supportive and expressive interventions, which appeared to be useful in the meeting itself, as reflected by the patient and therapist during the session. We focused on the implementation of supportive and expressive interventions by the therapist, and on the patient's recurring patterns of interpersonal themes and difficulties, based on the CCRT method (Luborsky & Crits-Christoph, 1998). The zoom-in analyses enabled us to understand the therapy process, its narratives and themes, and to identify main phases occurring throughout treatment.

### 2.6.2 | Quantitative analysis

Data analysis was conducted in SAS 9.3. First, we examined the development of the outcome measure (HRSD) over time to establish weak stationarity, which is a prerequisite for conducting multivariate time series analyses (Ram, Brose, & Molenaar, 2013). Similar to homogeneity assumptions in other statistical procedures, *stationarity* refers to the requirement that a process (i.e., time series) have a constant mean and variance-covariance overall at all time points (Tabachnick & Fidell, 2013). After each univariate time series was considered weakly stationary, the next set of analyses tested a mediation model using a set of multivariate time series. To examine a mediation model in which attachment avoidance (ECR-S) predicts alliance (WAI), which in turn predicts treatment outcome (HRSD), a series of three models was conducted: in the first model, ECR-S served to predict HRSD; in the second model, ECR-S served to predict WAI; in the third model, WAI served to predict HRSD while controlling for ECR-S. To examine a mediation model in which WAI predicts ECR-S, which in turn predicts HRSD, a series of three models was conducted: in the first model, WAI served to predict HRSD; in the second model, WAI served to predict ECR-S. In the third model, ECR-S served to predict HRSD while controlling for WAI. In all models, we examined the temporal precedence between the variables. To examine bidirectional associations between ECR-S, WAI, and HRSD over time, we used autoregressive cross-lagged modeling. In all the analyses, we controlled for autocorrelations for the outcome and included the predicting variable in a time lag.

## 3 | RESULTS

### 3.1 | Background

At the beginning of therapy, the patient was considered to have moderate to severe depression (as described in Table 1) and high levels of insecure attachment orientation, as manifest in high levels of avoidant and anxious attachment, according to ECR-S. At intake, the patient was diagnosed, in addition to MDD, with PTSD, according to the MINI, and with obsessive-compulsive personality disorder, according to the SIDP.

### 3.2 | Clinical change

The patient showed a clinically significant reduction in depressive and posttraumatic symptoms (Jacobson & Truax, 1991). At the beginning of treatment, at Session 1, the patient was noted to have moderate to severe depression, with a score of 17 on the HRSD and 33 on the BDI. At the end of treatment, at Session 16, the patient had a score of 7 on the HRSD and 15 on the BDI, indicating a clinically significant reduction in depressive symptoms; in fact, this BDI score signifies mild depressive symptoms. Furthermore, at the end of treatment, the patient did not display posttraumatic symptoms and was not diagnosed with PTSD, according to the MINI.

### 3.3 | Narrative analysis

The narrative analysis of the content of the therapy sessions suggests that the therapy consists of three main phases: (a) identifying the patient's CCRT, (b) working through the patient's CCRT, and (c) forming a corrective new

**TABLE 1** Patient process and outcome measures across the active phase of treatment

Session number	HRSD	BDI	WAI	ECR-S Avoidance	ECR-S Anxiety
1	17	33	4.42	4	3.83
2	19	28	4.33	3.67	2.5
3	17	25	4.42	3.83	3
4	18	25	4.75	3.67	3.33
5	18	26	4.42	3.67	3.83
6	13	23	4.42	3.67	3.5
7	14	22	4.83	3.67	3.33
8	16	26	4.67	2.67	3.5
9	19	30	5.58	2.5	3.33
10	14	20	5.08	3	3.67
11	13	19	5.17	2.83	3.17
12	12	19	5.33	2.5	3.67
13	12	20	5.25	2.83	4
14	14	17	5.58	2.67	3.67
15	14	20	5.5	3	3.83
16	7	15	5.5	2.67	3.83

Note. BDI: Beck Depression Inventory (Beck et al., 1961); ECR-S: Experiences in Close Relationships scale—short form; HRSD: Hamilton Rating Scale for Depression (Hamilton, 1960); WAI: Working Alliance Inventory (Horvath & Greenberg, 1989), answered concerning the therapist as an attachment figure (Wei et al., 2007).

experience of an adaptive close relationship with the therapist. As a result of the strong alliance with the therapist, the patient could share her traumatic losses, process her grief, and feel accepted and validated.

### 3.4 | First phase: Formulating the CCRT

The formation of the case formulation was the focus of the first phase of treatment. This phase consisted mainly of collecting relationship episodes (REs; Book, 1998), stories, and narratives the patient told the therapist about her interactions with others. The reported interpersonal interactions of the patient with significant others in the past (REs) enabled the therapist to better understand and conceptualize the patient's CCRT components: the *Wish* for recognition and acceptance of her emotional needs, and appreciation of her strengths; the RO of a critical and demanding environment that did not acknowledge her difficulties; and an *emotional* RS of feelings of guilt and depressive symptoms, together with a *behavioral* RS of withdrawal without explaining her needs, pretending that she was well and satisfied, something she referred to as “artificial functioning.” At the end of the first phase of treatment, the therapist and patient were in agreement about the components of the patient's CCRT. Based on the exploration of the CCRT in treatment, it appeared that these were the patient's characteristic patterns even before the perinatal losses and that the experience of dealing with others through minimizing and not acknowledging her pain at the time of the losses exacerbated her distress, making the maladaptive patterns even more rigid.

The following excerpts contain examples of the patient's CCRT components. Her *wish* for acceptance and recognition of her emotional needs was expressed as follows:

*Therapist: "...you would like a figure of someone you trust, both professionally and personally, that will give you, as you said, acceptance without judgment, someone who would listen to you and appreciate you."*

*Patient: "Exactly, I really need that. Even my mother and husband don't really understand why all this is so difficult for me... I need someone who can see me, my abilities and strengths, and understand my difficulties... Maybe someone who will know how to guide me to places that are good for me and that I can even contribute to them."*

The patient's RO of a critical and demanding environment, which does not acknowledge her difficulties was described as follows:

*Therapist: "You felt that you were not accepted and not seen, that people didn't appreciate the good in you."*

*Patient: "Yes, I felt that people expect me to move on, have another baby, and that will fix everything... In my former job, I always felt that they could not acknowledge my strengths... It was really hard for me to work there during all the fertility treatments and losses."*

Finally, the patient's RS of feelings of guilt, depressive symptoms, and withdrawal without explaining her needs were expressed as follows:

*Therapist: "On the outside, you functioned perfectly, and it was not possible to see and know what's going on inside you. I remember that you once said that it was kind of an artificial functioning. I'm thinking how hard and lonely it is to feel like that all of the time..."*

*Patient: "Yes, it was a feeling of total despair, it canceled every other possibility and I did not return to work... For a long time I felt depressed, and at that time nothing interested me, it was really terrible. I did not do anything and there was no drive and motivation for anything..."*

### 3.5 | Second phase: Working through the CCRT to gain insight into it

In the second phase of treatment, the therapist and patient worked through the patient's CCRT based on its manifestations in the relationship between them, as well as on the patient's relationships with significant others outside of the therapy room. They examined the patient's interpersonal patterns in concrete circumstances and found the CCRT at the basis of the patient's interpersonal conflicts, and their association to her depressive symptoms. This made it possible to understand how the patient's RS, a tendency to withdraw without explaining her needs, is expressed in her relationship with the therapist, and to work on changing it. For example:

*Therapist: "It happened also here, regarding your vacation, you said that you would make adjustments and accommodate yourself so that you could attend the treatment and the research sessions. It seems that you would do anything to make accommodations and not to be "not OK" and feel guilty because you have a commitment here. I think that your ability to say that there are things that are and are not suitable for you and that we can check whether it can work out in a way that is comfortable for you, is gently and gradually maturing."*

*Patient: "Yes, I'm starting to get the idea that it is allowed for me to say what I want and need, but it is still hard for me."*



### 3.6 | Third phase: Formation of a corrective experience between the patient and the therapist

In the third phase of treatment, based on their work on the patient's CCRT, the therapist and patient were able to form a genuine interaction in which the patient had a corrective experience with the therapist. The therapist did not act according to the patient's RO but rather accepted and validated her feelings while depicting her difficulties. In this way, the therapist actualized the patient's interpersonal wish. Below is an illustrative exchange between the two:

*Patient: "When I signed up for this treatment and research I did not know whether my current pregnancy was proper and healthy, and I knew that the situation might get worse or better. I knew that if this pregnancy would be unsuccessful and end in a loss once again, I would experience a serious crisis. I did not know what was going to happen."*

*Therapist: "I remember that we talked a lot about it at the beginning of treatment, and again what hits me is the power of the feelings you had when you started here, the uncertainty of what will happen in the future. I think about your feeling the need for support in case... It is truly the most difficult uncertainty a person can face."*

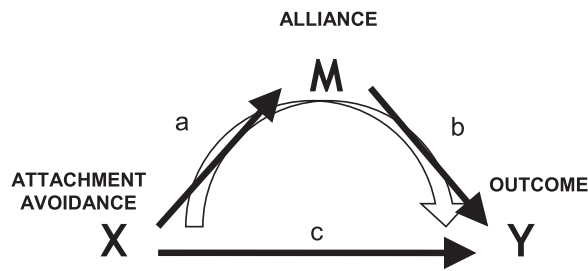
To conclude, the narrative analysis of the content of the therapy sessions suggests that the therapy included three main phases. At the first phase of therapy, the patient and therapist worked on identifying the patient's CCRT components. At the second phase of therapy, the therapist and patient-focused on understanding how the patient's avoidant interpersonal patterns are expressed and reenacted in the relationship between them and in the patient's relationships with significant others. Working through these avoidant interpersonal patterns, especially in the relationship with the therapist, led to a stronger alliance. It allowed the patient to acknowledge these avoidant recurring patterns and to work on changing them to deal with the depressive symptoms. At the third phase of therapy, based on the work on the patient's CCRT, the patient was able to go through a corrective experience with the therapist that enabled actualizing her interpersonal wish of acceptance and validation of her traumatic losses and difficulties.

### 3.7 | Quantitative analysis

The first model reveals that ECR-S cannot significantly predict outcome: ECR-S at any given time point was not associated with HRSD levels at the subsequent time point ( $B = -1.54$ ;  $SE = 2.04$ ;  $p = 0.46$ ). The second model reveals that ECR-S can significantly predict WAI: ECR-S attachment avoidance at a given time point predicted the level of the WAI at the subsequent time point ( $B = -0.71$ ;  $SE = 0.11$ ;  $p < 0.0001$ ). The opposite direction did not receive support ( $B = 3.87$ ;  $SE = 0.23$ ;  $p = 0.07$ ). The third model reveals that WAI can significantly predict outcome: WAI at a given time point predicted the level of HRSD at the subsequent time point ( $B = -3.57$ ;  $SE = 1.45$ ;  $p = 0.03$ ). The mediation model was found to be close to significance when examining the relationship between ECR-S avoidance and HRSD while controlling for the WAI ( $B = -4.92$ ;  $SE = 2.42$ ;  $p = 0.06$ ; Figure 1).

## 4 | CLINICAL PRACTICE AND SUMMARY

Perinatal loss has a high incidence. Many of the women who experienced it report a lack of social support and display severe interpersonal difficulties (Markin & Zilcha-Mano, 2018). Despite the need, there is little work to guide clinical practice with this population of pregnant women with a history of perinatal loss. In the present case



**FIGURE 1** A mediation model between attachment avoidance toward the therapist (ECR-S avoidance), alliance (WAI), and outcome (HRSD). ECR-S: Experiences in Close Relationships scale; HRSD: Hamilton Rating Scale for Depression; WAI: Working Alliance Inventory

study, two central approaches to working with this population were evaluated: one stressed the importance of focusing on expressive work in treatment, the other of focusing on supportive work. The narrative analysis suggests that both supportive and expressive work were important in this case. Although both may have played a role throughout the entire course of treatment, the expressive work appears to have been more dominant in the second phase of treatment, and the supportive work in the third phase. The quantitative analyses also reflected this pattern, demonstrating that the more dominant expressive work preceded the more supportive-focused work.

The importance of an expressive approach with this population received support from both the narrative and the quantitative analyses. According to the narrative analysis, the therapy consisted of three main phases: (a) identifying the patient's CCRT; (b) working through the patient's avoidant interpersonal patterns with the therapist and significant others, which led to a stronger alliance and allowed the patient to acknowledge and make changes in these recurring avoidant patterns to deal with her depressive symptoms; and (c) based on working through the patient's CCRT, the patient was able to form a corrective adaptive relationship with the therapist, which enabled actualization of her interpersonal wish. This theoretical model received support from the quantitative analyses, which suggests that changes in maladaptive representations of the therapist were followed by improvements in the alliance, which in turn resulted in symptom change. In other words, a reduction in maladaptive interpersonal patterns toward the therapist, in the form of attachment avoidance, made it possible to form a strong alliance, which in turn led to a positive outcome. These findings demonstrate that for a woman who suffered several traumatic perinatal losses, the expressive work and the change in maladaptive representations enabled a corrective experience to occur.

The gains in the alliance were possible after the expressive work was accomplished, causing a change in repetitive representations that until then were rigid. For patients who have suffered a traumatic loss, such as perinatal loss, expressive interventions may enable processing of the loss and grief. Only after change occurred and the rigid representations started to show greater flexibility, was it possible for a corrective experience to be formed. This case demonstrates the different roles alliance may play for the same patient in different phases of treatment (Zilcha-Mano, 2017).

The case study reported here has several important strengths. First, it presents potential ways of working with pregnant patients with a history of perinatal losses; little is known about effective interventions with this population. Second, it explores the potential contributions of supportive and expressive approaches in a case study, integrating both quantitative and narrative analyses. Third, the rigorous measurement of change factors allowed the investigation of the temporal relationship between changes in maladaptive patterns, changes in the alliance, and changes in symptoms. The findings suggest that changes in attachment avoidance toward the therapist contributed to changes in therapeutic alliance, which in turn contributed to changes in the outcome of treatment. Establishing a temporal relationship is a main component of causal inference, and maybe a potential strategy for identifying change processes and mechanisms, although studies are needed to determine the extent to which the identified processes can be generalized beyond the current case (Boswell, Anderson, & Barlow, 2014).

These strengths should be considered along with the limitations of the study. Although the present study deepens and adds to the available knowledge of processes of change in psychotherapy with pregnant patients following multiple perinatal losses, it is based on the process of one patient. Other cases may differ from the process depicted here, and therefore more research of larger samples is needed. The next step could be to examine multiple cases and analyze potential between-individuals differences in these within-individual processes (Boswell et al., 2014), using systematic qualitative and quantitative methods. Another limitation is the low reliability of the self-report questionnaire used to assess attachment orientation toward the therapist.

Two main frameworks were offered for working with pregnant patients following multiple perinatal losses. The findings from both narrative and quantitative analyses suggest that at first, an expressive work is dominant in treatment, enabling the formation of insight on maladaptive repetitive interpersonal patterns. This work facilitates change in the rigid patterns that may characterize the patient. When the patterns became less rigid, it was possible for a corrective interpersonal relational experience to be formed in the alliance with the therapist. Therapists are encouraged to identify their patients' rigid maladaptive interpersonal patterns, which may prevent any experience with another person to be perceived as a new corrective experience. After insight on these patterns is achieved in treatment, and the patient becomes more flexible, a window may open for a corrective experience to occur.

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