



MASSAGE THERAPY AND GROUP INTERPERSONAL PSYCHOTHERAPY

Benefits of combining massage therapy with group interpersonal psychotherapy in prenatally depressed women

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Summary One hundred and twelve pregnant women who were diagnosed depressed were randomly assigned to a group who received group Interpersonal Psychotherapy or to a group who received both group Interpersonal Psychotherapy and massage therapy. The group Interpersonal Psychotherapy (1 h sessions) and massage therapy (20 min sessions) were held once per week for 6 weeks. The data suggested that the group who received psychotherapy plus massage attended more sessions on average, and a greater percentage of that group completed the 6-week program. The group who received both therapies also showed a greater decrease in depression, depressed affect and somatic–vegetative symptom scores on the Center for Epidemiological Studies-Depression Scale (CES-D), a greater decrease in anxiety scale (STAI) scores and a greater decrease in cortisol levels. The group therapy process appeared to be effective for both groups as suggested by the increased expression of both positive and negative affect and relatedness during the group therapy sessions. Thus, the data highlight the effectiveness of group Interpersonal Psychotherapy and particularly when combined with massage therapy for reducing prenatal depression.

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Prenatal depression affects 10–50% of women in different samples, with the incidence being higher in low socioeconomic status samples (De Tyche et al., 2005; Stowe et al., 2005). The importance of prenatal intervention is highlighted by the depression-associated vulnerability to other problems such as caffeine, nicotine, drug and alcohol use

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(Diego et al., 2007; Zuckerman et al., 2002), as well as prenatal and perinatal complications (Jablensky et al., 2005; Nakano et al., 2004). Depressed women are also more likely to deliver prematurely (Field et al., 2004a; Sandman et al., 2006), and they often have neonates who require intensive care for postnatal complications including bronchopulmonary dysplasia and intraventricular hemorrhage (Chung et al., 2001).

Neonates of depressed mothers are also at greater risk for being low birthweight (<2500 g) and small for gestational age (<10th percentile) (Field et al., 2004a; Hoffman and Hatch, 2000), with low birthweight being one of the leading causes of fetal morbidity and mortality (National Center for Health Statistics, 2006). These infants continue to experience growth retardation across the first year of life (Rahman et al., 2004), and the growth and development problems continue across childhood and adolescence (Murray and Cooper, 1997).

In a study we conducted on prenatal depression effects on the fetus and newborn (Field et al., 2004a), prenatal mood and biochemistry levels were assessed in women with and without depressive symptoms during their second trimester of pregnancy. At the neonatal period, maternal and neonatal biochemistry, EEG and vagal tone levels were assessed, neonatal behavior states were observed, and the Brazelton Neonatal Behavior Assessment Scale was conducted. The mothers with depressive symptoms had higher prenatal cortisol levels and lower dopamine and serotonin levels. Mothers with depressive symptoms were also more likely to deliver prematurely and have low birthweight babies. The newborns of mothers with depressive symptoms had higher cortisol levels and lower dopamine and serotonin levels, thus mimicking their mothers' prenatal levels. The newborns also had greater relative right frontal EEG activation and lower vagal tone, again mimicking their mothers' prenatal EEG and vagal tone. On the Brazelton Scale, the newborns of depressed mothers had less optimal habituation, orientation, motor, range of state, autonomic stability and depression scores. A path analysis was conducted to assess the effects of prenatal depression and the mothers' prepartum biochemistry on gestational age and birthweight. As predicted in the model proposed, prenatal depression was related to prepartum cortisol and norepinephrine levels. Cortisol levels were, in turn, negatively related to gestational age, and norepinephrine levels were negatively related to birthweight.

Prenatal interventions for depressed pregnant women have included antidepressants, alternative therapies and psychotherapy. The literature on the use of selective serotonin reuptake inhibitors and other antidepressant medications during pregnancy is inconclusive (see Field, *in press* for a review). These studies have been limited by small sample sizes, uncontrolled study designs and unknown long-term medication effects. In addition, most women, even those already on antidepressants, have elected to stop taking antidepressants during pregnancy and have expressed a preference for the use of alternative therapies. Light therapy (Oren et al., 2002) and massage therapy (Field et al., 2004b) are examples of alternative therapies that have reduced prenatal depression.

Massage therapy had positive effects on prenatally depressed women including decreasing their depression

and cortisol levels and decreasing the incidence of prematurity and low birthweight (Field et al., 2004b). In this study, depressed pregnant women received a 20-min massage from their significant other twice per week from 20 weeks to 32 weeks gestation. Over the course of the study, the massage group experienced fewer symptoms of depression, and they had lower urinary norepinephrine and cortisol levels and elevated dopamine and serotonin levels compared to the relaxation and standard care control groups. The massage group also had fewer obstetric and postnatal complications including a lower rate of prematurity (all $ps < .05$).

Although only one study has been published on the use of Interpersonal Psychotherapy (IPT) with prenatally depressed pregnant women, several clinical trials have documented the efficacy of Interpersonal Psychotherapy in the treatment of postpartum depression. Interpersonal Psychotherapy is a time-limited form of psychotherapy that focuses specifically on interpersonal relationships and their improvement or changing expectations about relationships (Klerman et al., 1984; Stuart and Robertson, 2003). This therapy differs from other forms of therapy such as psychoanalysis by focusing on present rather than past relationships and by being a shorter term treatment, and from cognitive behavior therapy which focuses more on behavior change using homework assignments. The efficacy of this therapy was investigated by the National Institute of Mental Health Treatment of Depression Collaborative Research Program and was found to be equal to imipramine and Cognitive Behavior Therapy in the treatment of mild to moderate depression (Elkin et al., 1989).

Empirical studies have been conducted on Interpersonal Psychotherapy with postpartum depressed women both in individual and in group sessions. In a study on IPT using an individual therapy format, 120 postpartum depressed women were seen for 12 weeks and compared with a wait-list control group (O'Hara et al., 2000). The women receiving IPT showed a significantly greater decrease in Hamilton Depression scores and on Beck Depression Inventory (BDI) scores. In a similar study, but on a smaller sample ($N = 18$) receiving fewer sessions ($N = 10$ sessions), the postpartum depressed women were seen for 2 individual sessions followed by 8 IPT group sessions (Reay et al., 2006). Again, BDI and Hamilton scale scores decreased, and the women's relationships with their significant others improved. However, this study lacked a control group, and 67% of the women were on antidepressant therapy, confounding the effects of the group Interpersonal Psychotherapy. Similar limitations applied to another study using group interpersonal therapy with postpartum depressed women, namely a small sample size and no control group (Klier et al., 2001).

In the only published study on the use of Interpersonal Psychotherapy with depressed pregnant women, positive results were also noted (Spinelli and Endicott, 2003). The IPT group received 16 weeks of individual sessions, and a comparison group received the same number of sessions focused on parenting education. The IPT group showed significant improvement compared to the control group on 3 measures of depression including The Edinburgh Postnatal Depression Scale, The Beck Depression Inventory and The Hamilton Depression Rating Scale, and that group also had

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