Case Discussion of Child Parent Psychotherapy (CPP):
A multidisciplinary approach to support a pregnant patient with trauma

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GHOSTS IN THE NURSERY

- Infant Parent Psychotherapy
- Seminal paper – Selma Freiberg
- Reenactment of early unresolved (conflicts) scenes between the child who is now the parent and their current child
- Ghosts = forgotten feelings that are expressed through behaviors, perceptions and attitudes towards the child in the here and now
- Ghosts are not specific people or events
- Ghosts reflect the subjective experience in the conflicts of the parent-child relationship
- Ghosts = internal representations of relationships, unresolved conflicts
TRAUMA

FIVE RANDOMIZED CONTROLLED TRIALS

- 3 with trauma exposed children
  - Preschoolers exposed to domestic violence
  - Maltreated preschoolers
  - Infants
  - Other
  - Anxious children
  - Toddlers and depressed mothers
- Adaptations: Perinatal CPP

CREATION OF P-CPP

- P-CPP originated in findings from randomized CPP with preschoolers exposed to IPV against their mothers (disclosed that most IPV started in pregnancy)
- Launched a secondary prevention effort to treat pregnant women with a history of IPV
- 41 pregnant women reported IPV + childhood physical, sexual, emotional abuse, victimization by crime, community violence, accidental injury, traumatic separation and/or loss of attachment figures.
- All low income, publicly insured
- 24% were working, 52% experienced complications during pregnancy.
CREATION OF P-CPP CD

• 73% depression, 60% PTSD
• 69% pregnancy unplanned (additional stress)
• 30% women engaged in physical violence themselves against their partners (slapping, shoving, throwing objects)
• Important to assess and treat for maternal and mutual violence when working with battered women.

INTEGRATED MODEL OF CARE

• Addressing the nexus between maternal and child safety and well-being calls for coordination of services across health care providers
• Mayo Clinic is well positioned to support such a model of care because our Ob-Gyn Department works very closely with our Perinatal Clinic and they work closely with our Young Child Clinic.
• Women who experience trauma tend to start perinatal care late and use ER rather than regular pediatric appointments for their infants.
• Cultural factors (unfamiliar with US healthcare system) can lead to misunderstanding between mothers and physicians.
• P-CPP clinicians often serve as mediators between patient and their medical team.

PILLARS OF THERAPEUTIC ATTITUDE

• Notice feelings in the moment: attunement to present emotional experience as a port of entry to understanding. In P-CPP it is important to track body movement and posture as other ports of entry to identifying the manifestations of traumatic reminders and other strong emotions in the body.
• Speak the unspeakable: dare to use concrete words to describe the trauma. Guilt and shame can silence a person’s voice. It is important that clinician models for patient how to speak about difficult experiences that happened in the patient’s past.
• Find connections between experiences: from flee floating associations clinician finds a connection between motives, fears and wishes that patient might be talking about.
PILARS OF THERAPEUTIC ATTITUDE

- Remember the suffering under the rage: patients often protect themselves (their fear) by getting angry. Offering them a holding environment helps to modulate the rage and allows for other feelings to come to the surface.
- Seek out the benevolence in the conflict: Bowlby referred to security in attachment as “goal corrected partnership”. It is important to keep in mind that in conflict often both sides are correct.
- Offer kindness: remind empathically curious and nonjudgmental
- Encourage hope: highlight patient’s strengths

SPEAK THE UNSPEAKABLE

IMPLEMENTING P-CPP

- Referral process (at Mayo always perinatal clinic)
- Foundational phase: assessment and engagement (best if during first 2 trimesters of pregnancy)
- Core treatment phase (labor and delivery, meeting the baby)
- Recapitulation and termination (allows to revisit therapeutic trajectory, reflect on progress, promotes sustainability of therapeutic gains)
FOUNDATIONAL PHASE

- P-CPP as an opportunity to prepare for baby’s arrival (how is the new mother feeling about herself, her body, people around her)
- Informed consent for treatment
- Duration of treatment, estimated date for the end of treatment
- Circumstances of the pregnancy (views on pregnancy from mother and partner)
- Relationship with the intimate partner or father of the baby
- Information about mother’s life history, current circumstances, positive experiences, adversities, traumatic experiences, support networks
- Review of psychiatric symptoms

FOUNDATIONAL PHASE CD

- Psychological strengths and vulnerabilities (capacity for self-reflection, insight, affect regulation, coping, how open to interpretations)
- Sense of self as an individual and as a mother
- Cultural background (that includes historical trauma, rooted values, attitudes towards pregnancy, childrearing practices, acculturation level)

TAILORING FOUNDATION PHASE

- Physical sensations of pregnancy may serve as trauma reminder for mothers with hx of abuse → may lead to disorganization (fetal movements, repeated medical examinations)
- 1st trimester: circumstances of the pregnancy, partner’s reaction, family response, realization that baby will change their life
- 2nd trimester: positive and negative attributes to the fetus more distinct in response to growing reality of the baby.
- 3rd trimester: fears about childbirth, conflicts about becoming a mother. Fear that mother will be harmed by delivery, fear that they will harm fetus during delivery. Fear that they will repeat their trauma and maltreat their baby.
FEEDBACK SESSION - FORMULATION TRIANGLE

Treatment

Mother

Pregnancy

Baby

CORE TREATMENT PHASE

• Preparing a birth plan and a checklist of needed items
• Psychoeducation about caring for the newborn
• Assessment of cultural practices during and/or following birth
• Including the baby → facilitating secure attachment:
  ➢ Help parent notice baby's responses to various stimuli
  ➢ Help parent baby's request for intimacy
  ➢ Help parent understand when baby becomes trauma reminder
  ➢ Consolidate parents affect regulation when overwhelmed with caregiving practices

TERMINATION PHASE

• Usually when baby turns 6 months
• Continued focus on relevant clinical themes
• Celebration of clinical gains
SUMMARY

- Ali's case: P-CPP work helped her attach to the pregnancy and infant and manage her ambivalence about C-section
- P-CPP is generally thought of when trauma is the primary presenting psychiatric issue, especially intergenerational trauma
- Maternal trauma impacting pregnancy, ability to parent, attachment
- MN training available

References