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

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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

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TRAUMA

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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

Lieberman et al. 2005; 44, 1241-1248; Lieberman et al. 2006; 45(8), 913-918; Ghosh Ippen et al. 2011;35, 504-513; Toth et al. (14, 877-908; ; Lieberman et al 62, 199-209; Lieberman et al 29, 17-22; Lavi et al. 34(1), 64-82

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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 2ndary prevention effort to treat pregnant women with hx 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.

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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.

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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 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.

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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.

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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

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SPEAK THE UNSPEAKABLE

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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)

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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

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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)

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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.

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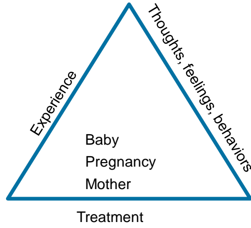
FEEDBACK SESSION- FORMULATION TRIANGLE



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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

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TERMINATION PHASE

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

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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

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