Perinatal Mental Health Advanced Psychotherapy Training

Presented by:

Postpartum Support International

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Learning Objectives

- Understand diagnostic coding related to perinatal mental health (PMH)
- Discuss evidence-based therapeutic approaches for PMH
- Describe evidence-based psychotherapeutic tools to address symptoms in PMH
- Discuss grief and loss related to PMH

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Intake/Interview

- Screening Tools/questionnaires
- Demographics
- Breast or bottle feeding? Pumping?
- Number of pregnancies and children
- Planned pregnancy?
- History of Infertility? Meds?
- "Birth Story" pregnancy and delivery
- What symptom is troubling you most?

Intake/Interview

- Spiritual History
- Social History
- Alcohol/Drug Use
- PMS?
- History of Abuse?
  - physical
  - emotional
  - sexual

Intake/Interview

- Personal/family history of mental illness (*diagnosed or not*)
- Previous pregnancy, birth, or postpartum difficulties
- Previous perinatal loss, adoption, abortion
- Past/current medications (*why stopped?*)
- Sleep habits (*time uninterrupted, who sleeps where? Who wakes? Pets in bedroom?*)

Intake/Interview

- Eating Habits
- Suicidal ideations
- Intrusive thoughts/images
- Thoughts of harm to infant
- Observe body language
- Interviews with family members
- Emotional Support?
- Losses or changes over the past year

The Spectrum of Perinatal Mood & Anxiety Disorders & The DSM-V

Beyond the Baby Blues…

DSM-V
Major Depressive Episode

- At least 2 weeks of:
  - Depressed Mood, or
  - Loss of interest/ pleasure
  - Mood is changed from baseline
  - Impairment in functioning

- 5 or more of the following:
  - Depressed mood or irritable most od day, nearly every day
  - Decreased interest/pleasure
  - Sig weight change (5%)/change in appetite
  - Sleep changes (insomnia/hypersomnia)
  - Change in activity: Agitation or retardation
  - Decreased energy/fatigue
  - Guilt, worthlessness
  - Decreased concentration
  - Thoughts of death/suicide

Pregnancy/Postpartum Major Depression

- Predominantly Symptoms of Major Depressive Disorder
- Loss, Grief
- Mild-Moderate Worry/ Anxiety
- Anger, frustration
- Guilt
- Suicidal Ideation (possible homicidal ideation)

Diagnosis: Major Depressive Disorder with Peripartum onset (new specifier in DSM-V!)

DSM-V

"Fifty percent of 'postpartum' major depressive episodes actually begin prior to delivery. Thus, these episodes are referred to collectively as peripartum episodes. Women with peripartum major depressive episodes often have severe anxiety and even panic attacks."

DSM-V Other Specified Anxiety Disorder or Unspecified Anxiety Disorder

- Person doesn't meet criteria for any specific anxiety disorder or adjustment disorder
- Mixed anxiety-depressive disorder: clinically significant symptoms of anxiety and depression but doesn't meet criteria for specific anxiety/ mood disorder
- **Other-specified**: spell out specific reasons criteria aren't met.
- **Unspecified:** used when choose not to specify, as when not enough info to make a diagnosis

Pregnancy & Postpartum Anxiety Disorders

- Pregnancy/Postpartum:
  - Panic Disorder
  - Posttraumatic Stress Disorder
  - Obsessive-Compulsive Disorder

DSM-V Panic Disorder

- Both of the following:
  - ➢Recurrent unexpected panic attacks
  - ➢At least one of the attacks has been followed by 1 month or more of the following:
    - Persistent concern about having additional attacks or their consequences (worry about going crazy, losing control, dying)
    - Significant maladaptive change in behavior related to the attacks (avoidance)
- Not due to substances or general medical condition
- Not another disorder

Pregnancy/Postpartum Panic Disorder

- Predominantly symptoms of panic disorder
- Some symptoms of depression related to panic attacks
- Worry about panic attacks
- Guilt/ Shame
- Loss
- Fear
- Generalized anxiety
- Possible agoraphobia

Pregnancy/Postpartum Panic Disorder

- Course:
  - Variable during pregnancy; worsens postpartum
- Associated risk factors:
  - Increased likelihood of SA
  - Decreased nutritional quality
  - Fears/agoraphobia can interfere with prenatal care and delivery
- Consequences:
  - Shorter gestation
  - Greater incidence of cleft palate & general congenital abnormalities in offspring *(Acs et al 2006; Banhidy et al. 2006)* (Ghadiali, 2007)

Pregnancy/Postpartum Panic Disorder

- Common Fears: Losing control
  - Vomiting
  - Effects of panic attacks on fetus, on childbirth, on parenting
  - Effects of meds on fetus/baby
  - Catastrophic interpretations of altered bodily sensations (Ghadiali, 2007)

- Diagnosis: Panic Disorder; Major Depressive Disorder with PP Onset; Anxiety Disorder NOS

DSM-V Posttraumatic Stress Disorder

- A. (1) Exposed to:
  - ➢ Death, threatened death, actual or threatened or serious injury, or actual or threatened sexual violence in the following ways:
  - ➢ Direct exposure
  - ➢ Witnessing the trauma
  - ➢ Learning that a relative/close friend was exposed to a trauma
  - ➢ Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g. medical, mental health)
- B. (1) Event is Reexperienced
  - ➢ Intrusive thoughts, nightmares, flashbacks, emotional distress/physical reactivity to reminders
- C. (1) Avoidance of trauma-related stimuli (thoughts, feelings & reminders)
- D. (2) Negative thoughts/feelings that began/worsened after trauma:
  - ➢ Inability to recall trauma, overly neg thoughts about self or world, negative affect, decreased interest in activities, feeling isolated, difficulty experiencing positive affect
- E (2) Trauma-related arousal and reactivity
  - ➢ Irritability or aggression, risky/destructive behavior, hypervigilance, heightened startle response, difficulty concentrating/sleeping
- F. Lasts more than 1 month
- G. Create distress or functional impairment
- H. Not due to meds, substances, or other illness

Pregnancy PTSD

- Rape-related pregnancies can initiate PTSD
- Memories of sexual abuse can be triggered by:
  - OB exams
  - L & D
  - Breastfeeding
- Traumatic Labor & Delivery and neonatal problems can initiate PTSD

(Ghadiali, 2007)

Postpartum PTSD

4 themes of PP PTSD

1) Going to the movies: Please don't make me go!
2) A shadow of myself: Too numb to try & change
3) Seeking to have questions answered & wanting to talk, talk, talk
4) The dangerous trio of anger, anxiety & depression: Spiraling downward
5) Isolating from the world of motherhood: Dreams shattered

(Beck, 2005)

Postpartum PTSD

- Symptoms of PTSD
- Event is typically related to childbirth/delivery
- May not present as PTSD initially
- Always assess for past trauma
- Always assess for traumatic childbirth process

Rule out: Other anxiety disorders/ depression

Diagnosis: Posttraumatic Stress Disorder, (Acute is duration less than 3 months, Chronic if duration over 3 months)

DSM-V Obsessive-Compulsive Disorder

- Either obsessions or compulsions:
  - ➢Obsessions:
    - Intrusive, repetitive and persistent thoughts, urges or images that cause distress
    - not simply excessive worry about real problems
    - person attempts to ignore or suppress thoughts/ images
    - Person may or may not recognize thoughts or images are a product of own mind
  - ➢Compulsions:
    - Excessive & repetitive ritualistic behavior the person feels driven to perform or something bad will happen.
    - Take up at least one hour/day
    - Rituals/mental acts performed to reduce sever anxiety caused by thoughts
- Person may or may not recognize these are excessive
- Cause marked distress or significantly interfere with normal life
- Rule out other Axis 1 diagnoses
- Not due to general medical condition/ substances

Pregnancy/Postpartum
Obsessive- Compulsive Disorder

- Symptoms of OCD directly related to baby
- Mental "obsessive" thoughts and/or images
- "Compulsive" ritualistic behaviors often include checking baby, searching for information on internet/books, etc.
- Some symptoms of depression related to OCD thoughts/ images
- Extreme anxiety/distress related to thoughts/ images

Rule Out: Postpartum Psychosis

Diagnosis: Obsessive-Compulsive Disorder or Major Depressive Disorder with Postpartum Onset

Pregnancy OCD

- High risk time for onset & exacerbation
  - Antepartum onset in 13-59% of OCD moms
  - Exacerbation in women with pre-existing OCD: 17%-43% during pregnancy; 29% postpartum
- Clinical presentation
  - Higher rate of aggressive obsessions
  - Fear of contaminating fetus or infant
  - Compulsive washing of items belonging to baby

(Brandes et al. 2004, Labad et al. 2005)
(Ghadiali, 2007)

2 **Presentations** of OCD in Pregnancy & Postpartum

"Postpartum OCD"

- Fear of carrying out obsessive thoughts/images, of "going crazy"
- Extreme anxiety/horror about thoughts
- Checking online, avoiding baby/triggers,

"Traditional" OCD

- Fear of germs, contamination, of dying or baby dying
- Extreme anxiety/horror of trigger itself
- Hand-washing, cleaning, avoiding "germs"
- High anxiety

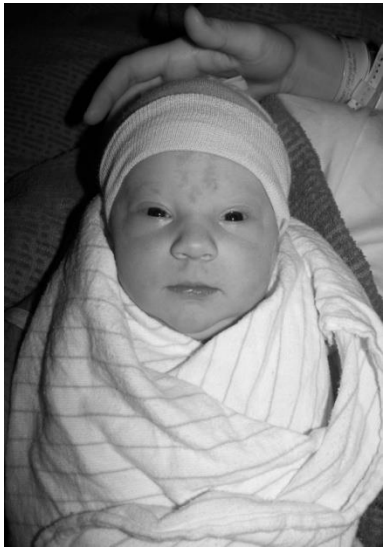
Case Examples

- Hannah—PPOCD
- Kaylee—Traditional OCD exacerbated in pregnancy/postpartum
- Delanie—Pre-existing OCD, then PPOCD
  - Exposure therapy treatment
    - Expose to thoughts—no
    - Expose to *anxiety about* the thoughts—yes

Postpartum OCD: Effects on parenting

- Avoidance of child
- Inadequate time for the child
- Involving child in rituals
- Inadequate nutrition
- Indirect effects of overall decline in functioning (financial, decreased social support)

(Ghadiali, 2007)



DSM-V Brief Psychotic Disorder

- Presence of one (or more) of the following:
  - ➢Delusions
  - ➢Hallucinations
  - ➢Disorganized speech
  - ➢Grossly disorganized or catatonic behavior
- Duration of episode at least 1 day but less than 1 month, with eventual full return to premorbid functioning
- Rule out: Mood Disorder with Psychotic Features, Schizoaffective Disorder, or Schizophrenia; also rule out substance-induced or general medical condition
- Specify: With Postpartum Onset if during pregnancy or within one month following childbirth
- Usually in response to an extreme stressor (APA, 2013) or series of stressors that overwhelm coping skills.

Postpartum Psychosis

- 1-2/1000 births
  - Risk=1:500
  - Women w/ previous PPP, Risk=1 in 7 (Sit et al, 2006)
- Symptoms:
  - Delusions (infant death, denial of birth, need to kill the baby).
  - Hallucinations
  - Extreme agitation
  - Hyperactivity
  - Insomnia
  - Mood lability
  - Confusion/ poor judgment
  - Irrationality
  - Difficulty remembering/concentrating
- **Rule Out:** Postpartum OCD

Postpartum Psychosis- Presentation

- Presents differently than other psychoses
  - waxing & waning sensorium, cognitive impairment, bizarre behavior
  - "Cognitive Disorganization/ Psychosis"
    - Cog. Disorganization in PP Psychosis, not in other psychoses
- Looks like: "mania alternating with melancholia"; bizarre & changing delusions; delirium, impaired sensorium; visual, tactile, olfactory hallucinations; cognitive impairment; confused memory
- May present to physicians like illness-related delirium
- Of those with PPP, most have mood disorder (91%)
- Bipolar episode unless otherwise noted

(Spinelli, 2006) (Wisner et al. in Spinelli, 2003) (Twomey,

PP Psychosis—Clinical Picture

- "Waxing and waning" disorder
  - Symptoms increase and decrease in intensity and severity
- Prominent symptoms of PPP:
  - hallucinations, usually auditory in nature; delusions; bizarre behavior, including disorganized thinking and speech, confusion, mood shifts, irritability, and lack of insight, judgment, decision-making skills, and self-care
- Not simply the result of a difficult childhood, significant life stress, or trauma, though these certainly put a woman at risk
- Postpartum Psychosis is a unique mental illness with symptoms that only appear after childbirth.
- *It is, in essence, a childbirth-related disorder.*
- Because so many women with PPP have no psychotic or violent indicators prior to childbirth or after recovery, Postpartum Psychosis has been called a "temporary madness." (Twomey, 2009)

PPP Clinical Picture

- "… an odd affect, withdrawn, distracted by auditory hallucinations, incompetent, confused, catatonic; or alternatively, elated, labile, rambling in speech, agitated or excessively active." (Brockington, 1996, p.200)
- Described as having "two different people at war" inside
- "A mom with PPP may be operating in two realities simultaneously". (Bennet, S.)
- "mothers suffering from PPP generally fit the mold of 'devoted mothers', but an obsession with being a 'good mother' causes insecurity about 'who they are and their parenting ability' that becomes a severe delusion and slips into a psychosis." (March, 2005,p.249)

Postpartum Psychosis= Bipolar Disorder

- "The data suggest that postpartum psychosis is an overt presentation of bipolar disorder that is timed to coincide with tremendous hormonal shifts after delivery." (Sit et all, 2006)
- Of mothers who develop PPP:
  - 72-88% have bipolar disorder or schizoaffective disorder
  - 12% have schizophrenia
- Contributing factors:
  - Hormone shifts
  - OB Complications
  - Sleep deprivation
  - High environmental stress (Sit et all, 2006)

PP Psychosis—Diagnosis

- *Dx:* Bipolar Disorder(BPD); Mood Disorder w/ psychotic features; Schizophrenic-spectrum disorder; Medical condition (thyroid, low B12); Drugs (amphet, halluc)
  - Women w/BPD or schizoaffective=>50% risk of PPP
  - PPP affects 74% of mothers w/BPD and a 1st degree relative who had PPP, compared w/ 30% of BPD women w/no family history.
  - Those who discontinue mood stabilizers at much higher risk of PPP or recurring BPD after childbirth compared w/those who continue meds (70% vs. 24%).

PPP & Infant Risk

- Women under the influence of Postpartum Psychosis do not *desire* to harm or kill their children.
- They lack the awareness and reality testing that would give them an intent to do harm.
- Theresa Twomey states, “I’ve never met or read about a woman with PPP who *wanted* to kill her child. Generally I’ve heard these mothers express it as a need or an absence of feeling or as if something else is controlling their actions, that the act or impulse is not of their own free will”.

Bipolar Disorder & DSM V

- BPD definition: occurrence of even one period of mood elevation not attributed to substance abuse or a GMC.
- Four categories of bipolar spectrum:
- Bipolar disorder type 1
- Bipolar disorder type II
- Cyclothymic disorder
- Other unspecified bipolar rand related disorder

Bipolar Episodes

- **Manic Episode:**
  - ➢ Distinct period of abnormally and persistently elevated, expansive or irritable mood lasting at least one week
  - ➢ At least 3 of the following symptoms:
    - Inflated self-esteem/ grandiosity
    - Decreased need for sleep
    - More talkative or pressured talking
    - Flight of ideas/ racing thoughts
    - Distractibility
    - Increase in goal-directed activity or psychomotor agitation
    - Excessive involvement in activities with a high potential for painful consequences

Bipolar Episodes (cont.)

- **Hypomanic Episode:**
  - ➢Persistently elevated/expansive/irritable mood for at least 4 days
  - ➢3 or more of following:
    - Inflated self-esteem/ grandiosity
    - Decreased need for sleep
    - More talkative or pressured talking
    - Flighty of ideas/ racing thoughts
    - Distractibility
    - Increase in goal-directed activity or psychomotor agitation
    - Excessive involvement in pleasurable activities that are high risk
  - ➢Episode associated with change in functioning
  - ➢Change is observable by others
  - ➢Not severe enough to cause marked impairment
  - ➢Not substance-related or general medical condition

Bipolar Episodes (cont.)

- Mixed Episode:
  - ➢Criteria met for both a Manic Episode and Major Depressive Episode within a 1-week period
  - ➢Severe enough to cause marked impairment in functioning
  - ➢Not substance-related or General Medical Condition

DSM-V: Bipolar 1 Disorder

- One or more Manic or Mixed episodes
- Often one or more Major Depressive episodes
- Specifier: with peri-partum onset (new in DSM-V)

Postpartum Bipolar 1 Disorder

- May appear at first to be productive
- Women report feeling “speeded up”
- Usually appears days after birth
- Postpartum mania typically not characterized by euphoric or elated mood but rather irritability and excitability
- Faulty reasoning, poor judgment, and distorted perceptions can quickly progress to impaired level

Rule out: Postpartum Psychosis

PP BPD I

- Marked increase in episodes PP, esp if prior PP episode
- 50% of bipolar women report depressive sx in pregnancy
- Abrupt med stop=increased risk of full-blown depression
- Many=history of premenstrual irritability or mood instability during infertility
- Up to 50% BP women develop PPD
- Between 20-50% develop PPP!

(Ghadiali, 2007)

DSM-V: Bipolar 2 Disorder

- One or more Major Depressive Episodes
- At least one Hypomanic Episode
- There has never been a Manic Episode
- Specifier: With peri-partum onset

Postpartum Bipolar 2 Disorder

- “PPD Imposter”
- Hypomania during pregnancy and/or after birth followed by severe depressive symptoms 2-3 weeks later
- Hypomanic symptoms often missed due to depressive symptoms
- Probe pregnancy/ postpartum and assess for periods of increased activity and decreased need for sleep, feeling confident and spontaneous, feeling unreal with spontaneous switch back to normal

PP BPD II

- May present as Treatment resistant depression
- Linked with h/o PMDD, adverse reaction to birth control
- In pregnancy=variable course, may feel better, may relapse
- PPBDII: predictable course
  - Hypomania immediately after birth, increased energy, poor sleep, short-lived, mistaken as excitement due to childbirth
  - Severe depression 2-3 weeks later= tx resistant
  - Increased risk of suicide with undiagnosed illness
  - Antidepressants worsen condition (Sichel, 1999; Ghadiali, 2007)

Bipolar II Disorder

- "This is the most unrecognized and undertreated mood problem we encounter…. In fact, some researchers estimate that 4 to 5% of the population suffer from it. We are always on the lookout for it, since misdiagnosis can lead to worsening of the condition."
  Sichel & Driscoll, p. 69, Women's Moods

Bipolar II Disorder

- "Unless this disorder is diagnosed, women who suffer from it have a difficult time with their moods throughout their childbearing years. They often complain of intense irritability, anger, and restlessness as their hormones fluctuate. Their relationships can be stormy"
    - Sichel & Driscoll, p. 69, Women's Moods

Great Resource for Bipolar I & II

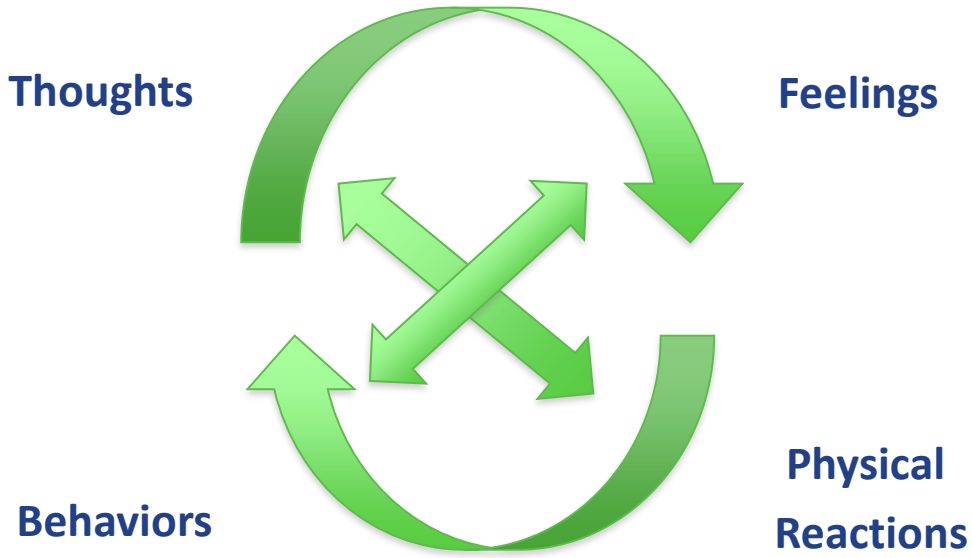
Jim Phelps, MD

www.psycheducation.org

Cognitive Behavioral Therapy - Review

Teaches clients to identify, evaluate and change dysfunctional patterns of thinking, resulting in changes of mood and behavior

Cognitive Behavioral Model - Review



Common CBT Components - Review

- Collaborative approach
- Education
- Stress and relaxation training:
  - Diaphragmatic breathing
  - Progressive muscle relaxation
- Desensitization/Exposure Therapy (caution)
- Assertiveness training
- Cognitive restructuring
- Training for resilience

CBT: Initial Sessions - Review

- Establish rapport and trust
- Explain cognitive model and therapy process
- Educate client about her disorder
- Normalize her difficulties and instill hope
- Determine and, if necessary, correct any expectations about therapy
- Collect additional information about client's problems
- Develop a goal list

Cognitive Behavior Therapy, Second Edition: Basics and Beyond by Judith S. Beck and Aaron T. Beck (Jul 13, 2011)

CBT with Perinatal Population

- Useful for negative self-talk, intrusive thoughts, anxious and depressed thoughts, unhelpful behaviors
- Collaborative approach to help them clarify goals
  - People are often telling perinatal mothers what to do
- Can be very relieving for them to feel like they can “do something” about what they are experiencing.

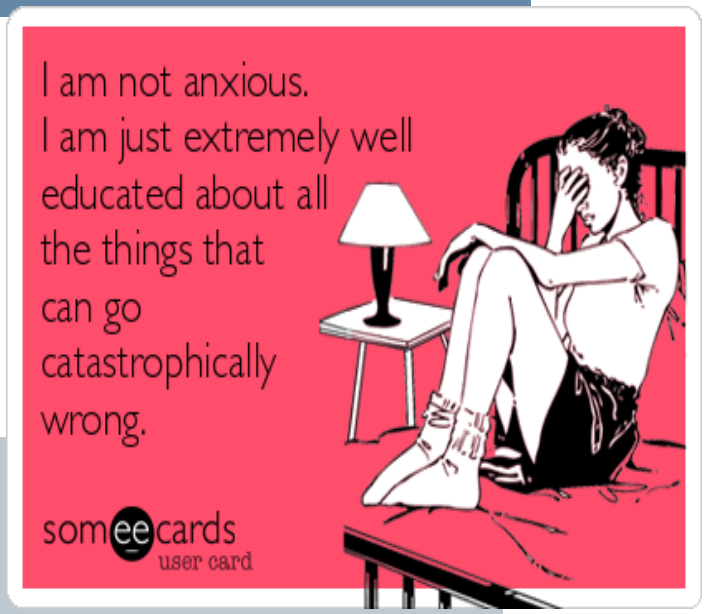
Considerations with Perinatal moms

- Relaxation techniques/skills and homework can sometimes feel like another thing to do.
- Start with small attainable goals
- Approaching skills
  - Important to explain the how AND the why these skills are important
  - Example, Sarah – Anxious moms want to be better yesterday

Speaking to the thoughts, feelings, behaviors

- People may not want to disclose what's going on
  - The clinician can use examples to help draw the thoughts
- CBT is a great backdrop for anchoring and distinguishing the "thoughts" from the person.
- Example of tool, using the CBT Model

Perinatal Thought Distortions



- It can be hard to see distorted thoughts as irrational when a baby is involved
- Rehearsing/Preparing for the worst case scenario can feel like good mothering
- Would she say to her friend what she's saying to herself?

Cognitive Distortions – Perinatal Style

- All or Nothing
- Overgeneralization
- Mental Filtering
- Discounting the Positives
- Overestimating the threat

- Catastrophic Thinking
- Fortune Telling
- Should statements
- "What if" thinking
- Discounting your coping skills

Cognitive Restructuring

- Identify automatic thoughts
- Connection between thought & feeling
- Evaluate thoughts/ Look for Cognitive Distortions
- Explore and modify underlying beliefs
- Differentiate between realistic and unrealistic threats
- Develop alternate perspectives

Common Perinatal Cognitive Restructuring Themes

- Identity loss/shifts
- Relationship changes/ role conflicts
- Loss/grief
- Self-esteem/self-worth
- Self-care
- Guilt
- Emotional overload (anger, fear, worry, frustration…

Managing Thoughts

Cognitive Therapy Worksheet

Situation	Thoughts	Feelings	Distortions	Coping Response

Intrusive or Obsessive Thoughts

- Overestimation of threat/inflated responsibility
- Excessive need to control intrusive thoughts
- Perfectionism and an intolerance for uncertainty
- Case Example

(Abramowitz, Khandker, Nelson, Deacon & Rygwall, 2006. The role of cognitive factors in obsessive-compulsive symptoms: a prospective study. Behavior Research and Therapy, 44, 1361-1374)

(Kleiman, Wenzel 2011. Dropping the Baby and other Scary Thoughts.)

Managing Obsessive Thoughts

- **Step 1:** Relabel
- **Step 2:** Reattribute
- **Step 3:** Refocus
- **Step 4:** Revalue

Perinatal CBT Resources

- Cognitive Behavioral Therapy for Perinatal Distress (Kleiman, Wenzel)
- The Pregnancy and Postpartum Anxiety Workbook (Wiegartz, Gyoerkoe)
- CBT Trainings:
  - Christine Padesky www.padesky.com
  - www.beckinstitute.org
  - www.Strongrootscounseling.com (CBT with PMADsTraining)

Using DBT for Perinatal Mothers

- There are only a few studies that show the effectiveness of DBT in the perinatal population.
- Can Be effective with multi-axial clients
- Can Be effective for emotional regulation
- Group Skills are potentially effective with group of perinatal mothers.

Wilson, H., & Donachie, A. (2018). Evaluating the Effectiveness of a Dialectical Behaviour Therapy (DBT) Informed Programme in a Community Perinatal Team. *Behavioural and Cognitive Psychotherapy,* 1-13. doi:10.1017/S1352465817000790

Apter-Danon G, Candilis-Huisman D (2005) A challenge for perinatal psychiatry: therapeutic management of maternal borderline personality disorder and their very young infants. Clin Neuropsychiatr 2:302–314

BEHAVIORAL ACTIVATION (BA)

- BA is a Third-Wave Behavioral therapy for depression (along with DBT, ACT, etc)
- Based on classic work of Peter Lewinsohn and colleagues
- Main premise:
  - Insufficient reward leads to depression, Excessive punishment leads to depression
    - As one becomes more depressed, they have less access to rewards, leading to an increase and maintenance of depression
    - May experience increased “punishers” due to avoidance of important life tasks or dysfunction in important relationships
  - By increasing rewards and decreasing punishments, depression will diminish

BEHAVIORAL ACTIVATION (BA)

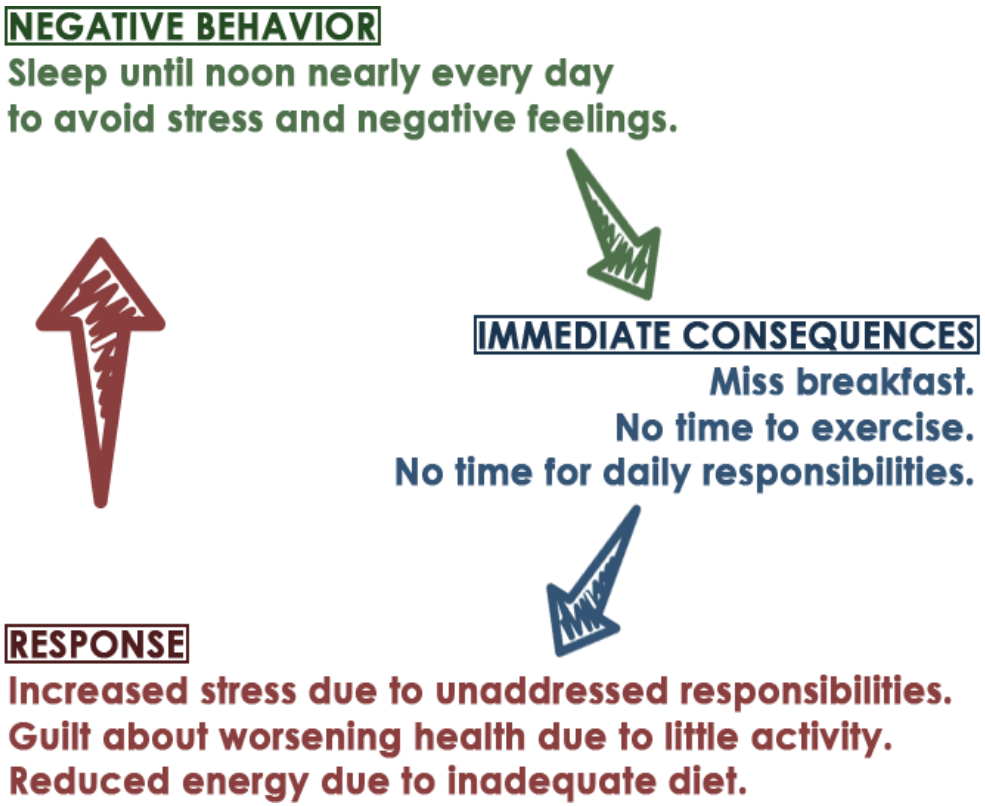


Image from: https://www.therapistaid.com/therapy-guide/behavioral-activation-guide

BA - FORMAT

- BA therapy can be delivered within the context of individual or group therapy
- Short term, typically 8-24 session
- Clients identify hierarchy of rewarding activities based on ease and level of reward, create a schedule of these activities and monitor the impact on their mood
- Can be delivered within the context of a peer support model
  - Alma program- Sona Dimidijian, PhD at university of colorado

BA – CORE COMPONENTS

- **Action** plan to attain goals:
  - Assess mood and behavior
  - Choose alternative behaviors
  - Try them out, practice in session
  - Integrate results across situations
  - Observe results
  - Never give up!
- **GEMS**: Goals of Enjoyment and Mastery
- **ABCs**: Antecedents, behaviors and consequences
- **TRAP**: trigger – response – avoidance patterns
- **Trac**: trigger – response – alternate coping

BA - resources

- American psychological association:
  - https://www.div12.org/treatment/behavioral-activation-for-depression/
  - Includes recommended books and client apps
- Therapist Aid- free worksheets, videos, and other resources
  - https://www.therapistaid.com/therapy-guide/behavioral-activation-guide
- Specific to perinatal mental health
  - http://www.westword.com/news/alma-offers-innovative-support-for-women-with-perinatal-depression-9544598
  - Recorded Webinar with Dr. Gollan
    - https://www.div12.org/product/using-behavioral-activation-treatment-to-treat-perinatal-mood-disorders/

MOTIVATIONAL INTERVIEWING

- Technique for working collaboratively with a client, helping to encourage them to strengthen their commitment for behavioral change
- Developed by william R miller (1980's), initially to treat substance abuse, but has since been applied to many health-related behaviors"
- "MI uses a combination of open questions, reflection, Affirmation and summaries to engage the patient in treatment, as well as giving information and advice in a respective and collaborative manner." C. marienfeld, *Motivational interviewing for clinical practice.*
- Easily integrated with other forms of intervention, particularly behavioral activation, cbt, etc

MOTIVATIONAL INTERVIEWING

- Not often used as a primary strategy when working with women in the perinatal period, other than as related to substance use
- Still has merits as a behavioral strategy in perinatal populations
  - Decreasing secondary teen pregnancy (Meckstroth & berger 2017)
  - When delivered by nurses during pregnancy visits, increases likelihood of seeking help and attending psychotherapy postpartum (holt, milgram & GemMIll (2017)
  - Effective and well-received by low-income mothers engaged in a home-visitor program (sampson, villareal & rubin (2014)

MOTIVATIONAL INTERVIEWING - resources

- Motivational interviewing network of trainers (mint) – for training
  - www.motivationalinterviewing.org
  - Not perinatal specific
- Helpful worksheets
  - https://www.psychologytools.com/category/motivational-interviewing
- books
  - Motivational Interviewing: Helping People Change (Miller & Rollnick, 2012)
  - Motivational interviewing in healthcare: helping patients change behavior (rollnick, miller and butler, 2007)
  - Building motivational interviewing skills: a practitioner workbook (rosengren, 2017)

Interpersonal Psychotherapy

IPT

IPT for Postpartum Depression

- Adapted from traditional IPT for perinatal women
- No additional training in IPT required to provide IPT for perinatal women if already IPT trained
- Additional training in perinatal psychology and physiology is advised

Stuart, 2012

IPT for PPD—Theory

- Attachment and Interpersonal Theory (Stuart, 2006)
  - Attachment theory—the relationships formed early in life contribute to help-seeking behavior and coping skills throughout life (Bowlby, 1988)
  - Interpersonal theory—unhealthy patterns of communication lead to problems in interpersonal relationships (Kiesler, 1996)

IPT for PPD—Biopsychosocial Model

- Biopsychosocial model
  - Biological, psychological, and social aspects
- PPD Client's functioning is viewed as a product of:
  - 1) attachment style, personality, and temperament
  - 2) biological factors (genetics, physiological functioning)
  - 3) social relationships and support
- This model is discussed with client to explain the underlying "reasons" for symptoms and distress

Stuart, 2012

IPT Treatment Targets/Problem Areas

- Biopsychosocial Model Treatment Targets
  - Psychological/psychiatric symptoms
    - Psychotropic medications supported, when indicated
  - Interpersonal relationships
  - Social support system

- Problem areas

1) Interpersonal Disputes
2) Grief and loss
3) Role Transitions

*There used to be a fourth problem area, “Interpersonal sensitivities/deficits,” which was discontinued since it’s better understood as a client’s attachment style than an interpersonal problem.
(Stuart, 2012)

IPT for PPD—Therapeutic Tactics

- Tactics Used for PPD Treatment
  - Interpersonal Problem Areas (3)
  - Interpersonal Inventory
  - Interpersonal Formulation
  - Short-term acute treatment, followed by maintenance treatment
  - Nontransferential focus of interventions
  - Present focus

(Stuart 2012; Stuart & O'Hara 1995)

IPT for PPD—Therapeutic Tactics

- Tactics Used for PPD Treatment (continued)
  - Collaboration and equal consensus
  - Supportive and directive therapeutic stance
  - Psychoeducation
  - Communication analysis
  - Interpersonal incidents
  - Role playing

(Stuart 2012; Stuart & O'Hara 1995)

IPT for PPD—Assessment

- Goal: Identify the acute crisis/crises behind why client is seeking treatment
- Done with client as a team
- Explain biopsychosocial model & work together to identify contributing factors for depression and distress
- Explain client's role in IPT treatment

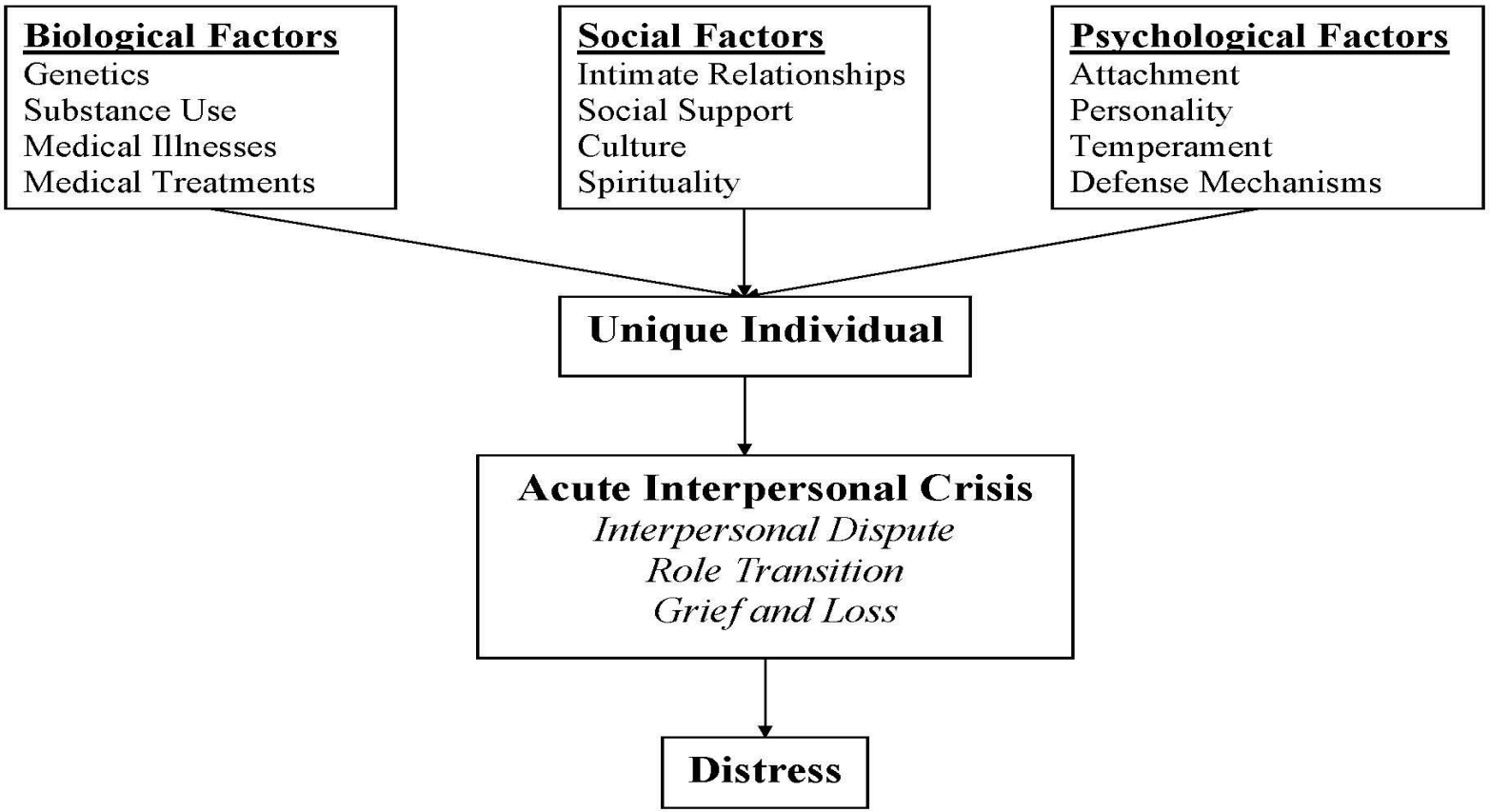
(Stuart & O'Hara, 1995; Stuart, 2012)

IPT for PPD—Assessment

- Evaluate symptoms, begin interpersonal inventory, identify problem area on which to focus treatment, interpersonal formulation of problem
- Examine "3 Interpersonal Problem Areas" to identify issues
  - Interpersonal disputes, grief/loss, role transitions
  - Focus on relationships with: 1) infant, 2) partner, 3) family of origin, 4) partner's family, and 5) friends
- Assess FULL range of emotional responses to motherhood
  - If strongly negative emotions toward infant are discovered, provide a more thorough evaluation for psychotic features, HI and SI
- Assess marital/partner relationship thoroughly (i.e. expectations, roles, intimacy, communication, etc.)

(Stuart & O'Hara, 1995; Stuart, 2012)

Interpersonal Formulation



Interpersonal Psychotherapy Institute

IPT for PPD—Treatment Planning

- Goal: Short-term treatment of the client's acute distress
- Typically weekly sessions in acute stages, and then biweekly sessions as client stabilizes
- Involve partner in treatment when possible
- Therapist remains available to client after interpersonal issues are resolved, should a recurrence occur
- Another round of short-term treatment may be indicated if/when new crises arise

Stuart, 2012

IPT for PPD—Intermediate Sessions

- Address common “themes”

1. Interpersonal disputes—partner issues- lack of help/support, childcare, expectations; family issues- criticism, poor support
    1. Therapeutic goal: Problem-solving plan and action (may involve partner)
2. Role transitions—return to work, ”balance,” identity, priorities
    1. Therapeutic goal: assist client in combining old and new roles
3. Grief/loss—perinatal loss, health of infant, delivery, past losses, past abuse/abandonment
    1. Therapeutic goal: facilitate mourning, develop relationships to support those that have been lost

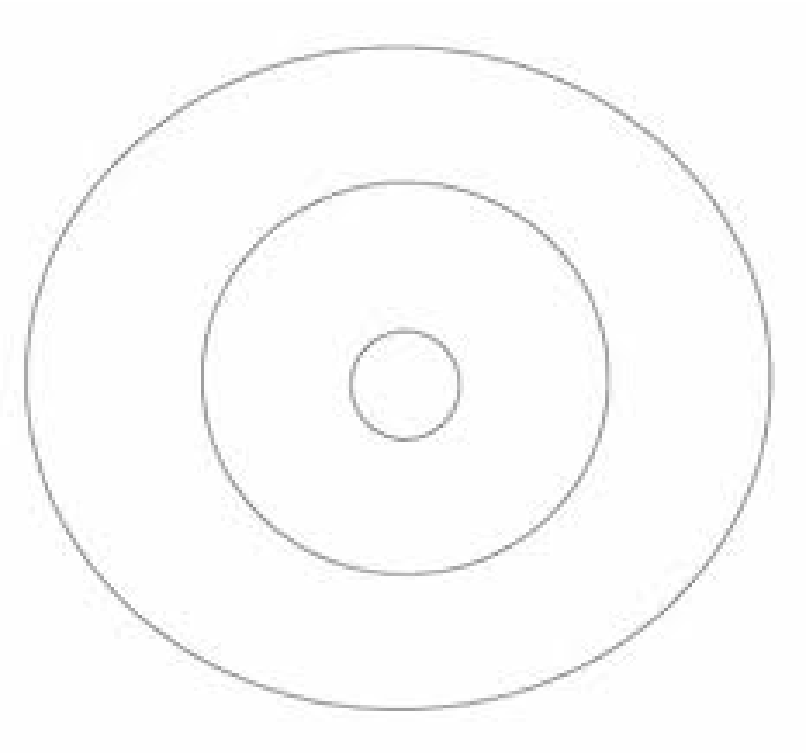
IPT for PPD—Techniques

- Psychoeducation—educate both partners about PPD, child development, relationships, etc.
- Communication analysis—discuss interpersonal dispute dialogue and identify communication flaws/issues to work on
- Role playing—includes "role reversal," or therapist playing part of patient while patient plays role of partner
- Help client develop problem-solving skills
- Directive approach, but make clear IPT teaches skills for client's own recovery

(Stuart, 2012)

IPT for PPD—Interpersonal Inventory

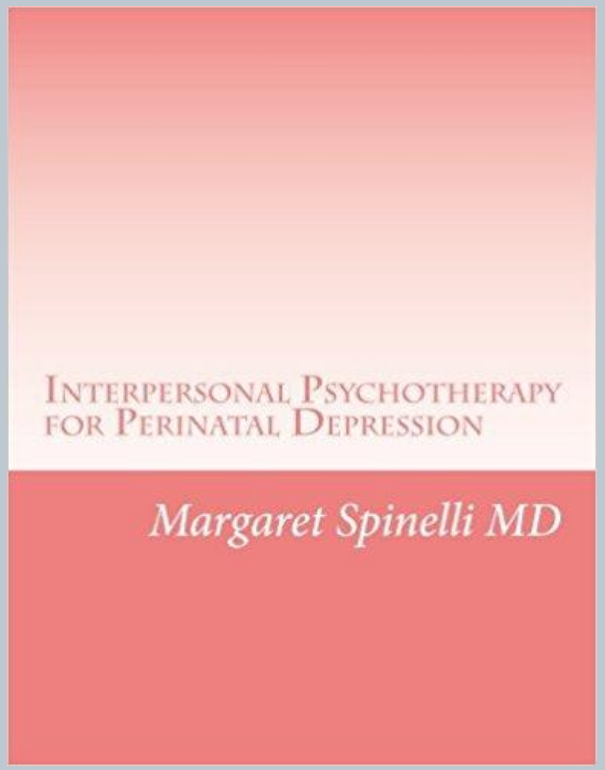
- Intimates: family, close friends
- Social Associates: friends, colleagues/coworkers, etc.
- Casual contacts: anonymous social relations, non-close relationships

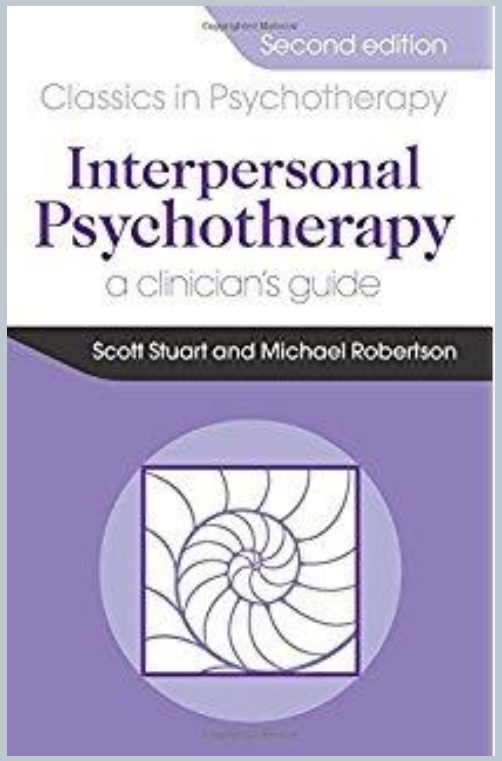


IPT for PPD—Final Sessions

- IPT doesn't use "termination" but rather "conclusion" of treatment
- Anticipate future problems and discuss in final sessions, setting up "maintenance plan" as needed
- Maintenance care is set up as needed to prevent relapse and manage recurrent symptoms
- Maintenance treatment may include monthly follow up sessions if at high risk, or may be less frequent if low risk for relapse

IPT Manuals





Eye Movement Desensitization and Reprocessing

EMDR

Eye Movement Desensitization and Reprocessing (EMDR)

- An integrative psychotherapy approach, incorporating elements from various treatment approaches
- Developed in 1987 by Dr. Francine Shapiro—noticed that “eye movements can reduce the intensity of disturbing thoughts”.

EMDR

- Proven effective in the treatment of trauma (in over 20 controlled studies)
  - PTSD most common use
  - Also used for: Panic attacks, complicated grief, dissociative disorders, phobias, pain disorders, performance anxiety, stress reduction, addictions, abuse, personality disorders, body dysmorphic disorders

(EMDRIA, 2018)

EMDR

- EMDR significantly decreases symptoms of PTSD, anxiety, depression and increases mental health and social functioning in women with traumatic birth experiences.

(Van Deursen-Gelderloos & Bakker, 2015)

Eye Movement Desensitization and Reprocessing (EMDR)

- EMDR seeks to transform unhealthy and disturbing input (thoughts, memories, emotions, sensations) into healthy psychological integration
- Seems to have a direct impact on the way the brain processes info—Deconditions the "one moment frozen in time" and reconditions normal information processing
- EMDR seems to be similar to REM sleep/dreaming—helps see disturbing events in a new way
- Uses comprehensive, detailed treatment protocol focused on

1. Past events that have laid the groundwork for dysfunction
2. Present circumstances that elicit distress
3. Future imagined events

(EMDR Institute 2018; EMDRIA 2018)

Eye Movement Desensitization and Reprocessing (EMDR)

- 8 Phases of Treatment

1. History & treatment planning (1-2 sessions)

   --Goals: thorough history, Identify specific "targets," develop treatment plan

2. Preparation (1-4 sessions)

   --Goals: establish relationship of trust, explain theory of EMDR & what to expect during/after treatment, teach relaxation skills

3. Assessment

   --Goals: "access each target in a controlled, standardized way so it can be effectively processed," client identifies a negative and positive belief and rates it, client identifies negative emotions and physical sensations associated with target

4. Desensitization

   --Goals: focus on client's disturbing emotions and sensations using eye movements until client's SUD scale scores lower to 0, 1, or 2.

(EMDRIA 2018; Shapiro & Forrest 2004)

Eye Movement Desensitization and Reprocessing (EMDR)

5) Installation

--Goals: to increase strength of positive belief to replace negative belief

6) Body scan

--Goals: Client scans body for residual tension and these sensations are then targeted for reprocessing

7) Closure

--Goals: end of every session, uses self-calming techniques to ensure client leaves feeling better

8) Reevaluation

--Goals: opens each new session, check in to ensure positive results have been maintained and identify new targets

(EMDRIA 2018; Shapiro & Forrest 2004)

EMDR Info & Training

EMDR International Association

https://emdria.site-ym.com/

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Couples Therapy

"The single most important thing a husband can do for his wife who is suffering from postpartum depression is to be with her. To simply be with her." (Kleiman, 2006)

Most research has been done with heterosexual couples

- Use inclusive language
- Remember to check on partner

Relationships

"Always assume you're working with a family"

- Couples Therapy
- Family Therapy
- Role Changes
- Relationship changes
- Communication
- Intimacy/Sex Therapy
- Grief/loss
- Self-Care
- Parenting

Couples Therapy

- Assessing the partnership:
  - How was contact initiated?
  - What has mom disclosed about the relationship?
  - What is therapist's perception of the relationship?
  - Who is motivated for treatment?
  - Who is engaged in the process?
  - How similar or conflicting are their interpretations of the situation? (Kleiman, 2006)

Couple's Therapy: *Issues to Address*

- Communication difficulties
  - Observe/ analyze communication styles and skills
  - Teach how to see one another's perspectives
  - Teach how to communicate own needs and expectations clearly
  - Model direct communication
- Communication Skills:
  - Negotiation skills rules
  - Reflective listening
  - "I" statements
  - Time-outs
  - Time limits
  - Writing down complaints
  - Asking for permission to give criticisms

Couple's Therapy: *Issues to Address*

- Communication Skills:

  Deeper Understanding

  - Teach empathy and self-awareness
  - Being "in the box"
  - "Seeing the other" exercise
  - "Doing the right thing"

    (Warner, 2001)

Couple's Therapy: *Intimacy & Sex*

- Intimacy -Strategies
  - Define intimacy for couple
  - Identify struggles with intimacy and sex
  - Help each partner identify and express intimacy needs
  - Help couple learn to talk openly about sex
  - Teach various ways to achieve intimacy
  - Address specific sexual difficulties as needed
  - Discuss need to strengthen "positives" in relationship
  - Help couple identify strengths to build on
  - Assign exercises to build friendship
  - Make a list of activities the couple enjoys
  - Create an intimacy hierarchy or list
  - Assign "couple time" each week
  - Help couple make their relationship a priority!

Couples Therapy—Self-Care

- Self-Care (vs. selfishness)
  - Identify self-care struggles: nutrition, sleep, exercise, time for self, time away, etc.
  - Explain how self-care enriches the relationship
  - Teach couple importance of working together to meet self-care needs
  - Use “permission-giving” to help couple take time for selves
  - Help with practical solutions to improve self-care

Couples- Role Transitions

- Role Transitions--Help couples understand the importance of acknowledging and adjusting to role changes
  - Explore Expectations for roles in phases of life
  - Discuss Prepartum roles vs. Peripartum roles
  - Discuss losses related to current roles
  - Help each partner express needs and expectations clearly

- Case example: Christine and Jeff

Couple's Therapy: *Issues to Address*

- Other Topics to Address:
  - Problem-solving skills
  - Anger management skills
  - Conflict resolution skills
  - Time management skills
  - Stress management skills
  - Family Planning
  - Parenting issues
  - Sleep Strategies

- Family Therapy

Fathers/Partners & PMADs

- #1 risk factor for PPND= depressed partner
- Both parents PPD= further damage to infant relationship
- Father-infant relationship may suffer with depressed mom (she can facilitate or constrain relationship)
- High co-occurrence of depression in couples
  - Incongruous between couples reports of depression and EPDS scores

(Goodman, 2005)

Fathers/Partners & PMAD

Findings: (Goodman, 2005)

- Maternal PPD affects fathers in negative ways
  - This may then affect father-infant interaction
- Fathers didn't compensate by behaving "more optimally"
- Fathers don't offer buffering/protection for child with PPD mom
- Only variable that predicted father-infant interaction was maternal parent-child dysfunctional interaction
  - Moms felt less positive about relationship with infant= partners had less optimal interactions

Fathers & PMAD

- Common obstacles:
  - Unhelpful family & friends
  - Insurance companies
  - Job/financial concerns
  - Hostility/rejection
  - Stigma of depression
  - Your own attitudes
  - Legal issues

(Klinker, 2004)

Paternal Postnatal Depression (PPND)

- Paternal Postnatal Depression (PPND) affects up to 10% of new dads throughout the world and as many as 24% of dads in the US (Paulson et al, 2010)
- Some experts believe the numbers may be even higher—men less likely to report they're depressed
- Biggest risk factor=depressed mom
- Considering that up to 20% of all new *moms* get depression, it makes sense that a high percentage of dads would too.

Paternal Postnatal Depression (PPND)

Symptoms:

- Irritability
- Isolating/Withdrawing from relationships
- Working a lot more or less
- Low Energy
- Fatigue
- Low motivation
- Poor concentration
- Changes in weight or appetite
- Impulsivity
- Risk-taking behaviors, often including turning to substances (alcohol, prescription drugs, etc)
- Physical symptoms (headaches, muscle aches, stomach/digestion issues)
- Anger and outbursts
- Violent Behavior
- Suicidal Thoughts

What Causes Paternal Postnatal Depression?

- Sleep deprivation
- Psychological Adjustment to Parenthood
- Personal or Family History of Depression
- Hormones—Dads/partners' hormones shift, too! "Testosterone levels go down & estrogen levels go up…Lower levels of testosterone are associated w/depression in men" (Will Courtenay in Neff)
- A Depressed Partner—Up to half of men with depressed partners are depressed
- Relationship Stress—#1 non-biological cause of PMADs
- Feeling disconnected from Baby or Partner
- **Other factors that may contribute to PPND:** Recent loss or trauma, unplanned pregnancy, financial/work stress, family or other life stress, and a colicky baby

About Father's PMAD

David Levine's Story Clip

On YouTube

Need…

- Family-centered approach: (Goodman, 2005)
  - Target maternal depression
  - Target father-infant interaction
- Strong relationships
  - Research: woman's depression improves markedly w/ consistent partner support & dads/partners' depression improves w/mom's improvement (Kleiman, 2006)

Trauma

And Trauma-Informed Care

Refresher on Trauma

- Traumatic experiences are those that are overwhelming, invoke intense negative affect and involve some degree of loss of control and/or vulnerability. The experience of trauma is subjective and developmentally bound.
- It is in the eye of the beholder. What happened is not nearly as important as what the trauma means to the individual.
- Individual trauma results from an event, series of events or set of circumstances that is experienced by a individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Responses to Trauma

- Emotional
- Emotional dysregulation
- Numbing
- Physical
- Somatization
- Hyperarousal/ Hypervigilance
- Sleep disturbance
- Flashbacks
- Dissociation
- Behavioral
  - self-destructive,
  - substance use,
  - self-injury,
  - avoidance

Perinatal Women with Trauma Histories

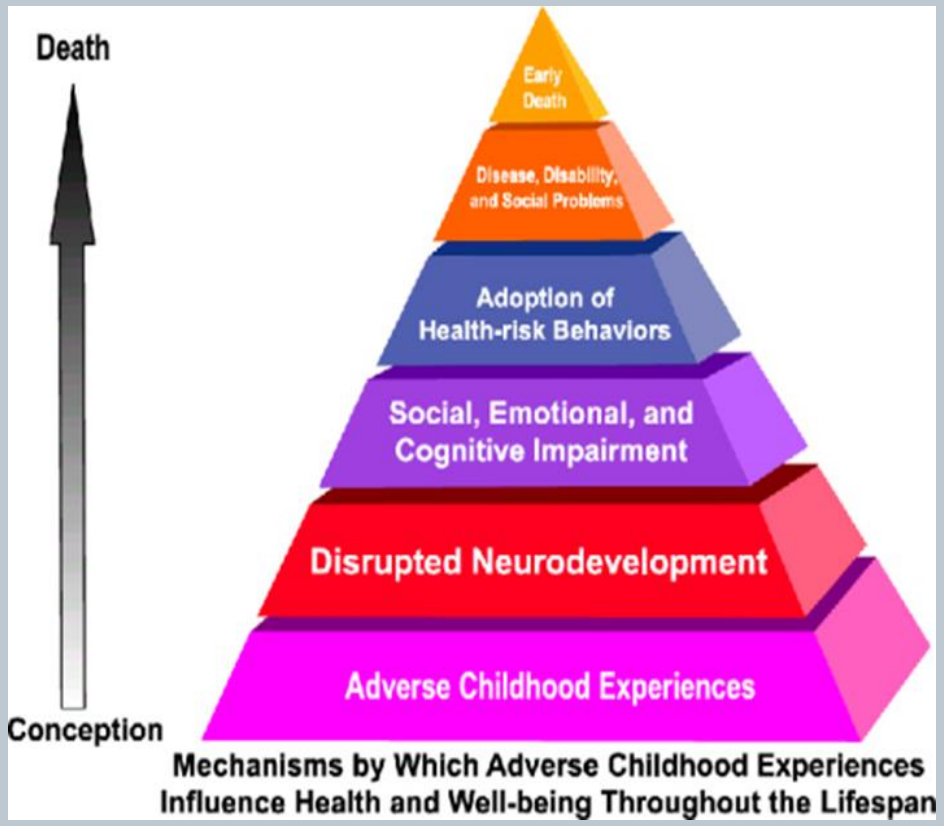
- Assessment of past trauma is paramount
- Some women do not register their histories as traumatizing, but they feel the effects of trauma.
- Many times, past trauma unexpectedly resurfaces during the perinatal period.

Perinatal women with Trauma Histories

- Symptoms may represent behaviors that were adaptive a the time of trauma
- Increased risk for transgenerational transmission of trauma
- The use of social support is protective against postpartum depression in at-risk women.

Sexton M.B., Bennett D.C., Muzik M., Rosenblum K.L. (2018) Resilience, Recovery, and Therapeutic Interventions for Peripartum Women with Histories of Trauma. In: Muzik M., Rosenblum K. (eds) Motherhood in the Face of Trauma. Integrating Psychiatry and Primary Care. Springer, Cham

ACES = Adverse Childhood Experiences



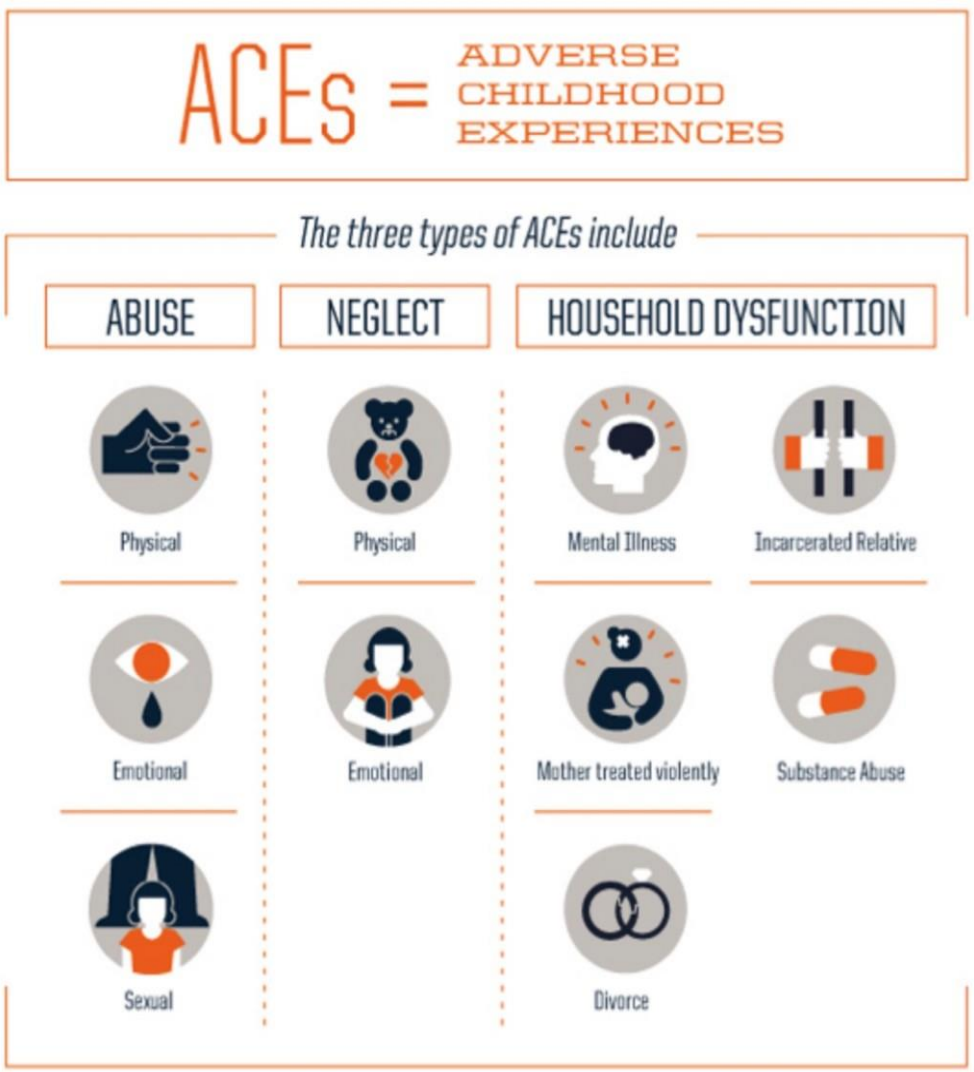
Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study.

Felitti VJ[1], Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS.

Am J Prev Med. 1998 May;14(4):245-58

ACES Questionnaire



ACES Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you?

or Act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you?

or Ever hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever…

Touch or fondle you or have you touch their body in a sexual way?

or Try to or actually have oral, anal, or vaginal sex with you?

Yes No If yes enter 1 _____

ACES Questionnaire Cont'd

4. Did you often feel that …

No one in your family loved you or thought you were important or special?

or Your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you often feel that …

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?

Yes No If yes enter 1 _____

ACES Questionnaire cont'd

7. Was your mother or stepmother:

Often pushed, grabbed, slapped, or had something thrown at her?

or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

URBAN ACES

- Expanded ACES questionnaire, 40 Questions

- Asks about factors of racism, poverty, abuse, pregnancy age, sexual activity, neighborhood, bullying, medical issues and more.

(http://www.philadelphiaaces.org/philadelphia-ace-survey)

What is Trauma-Informed Care (TIC)?

- Trauma -informed care embraces a perspective that highlights adaptation over symptoms and resilience over pathology."

  Elliot, Bjelajac, Fallot, Markoff, & Reed 2005

- A trauma-informed approach… involves viewing trauma through an **ecological and cultural lens** and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic.

- TIC involves **vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize** individuals who already have histories of trauma, and it upholds the **importance of consumer participation** in the development, delivery, and evaluation of services

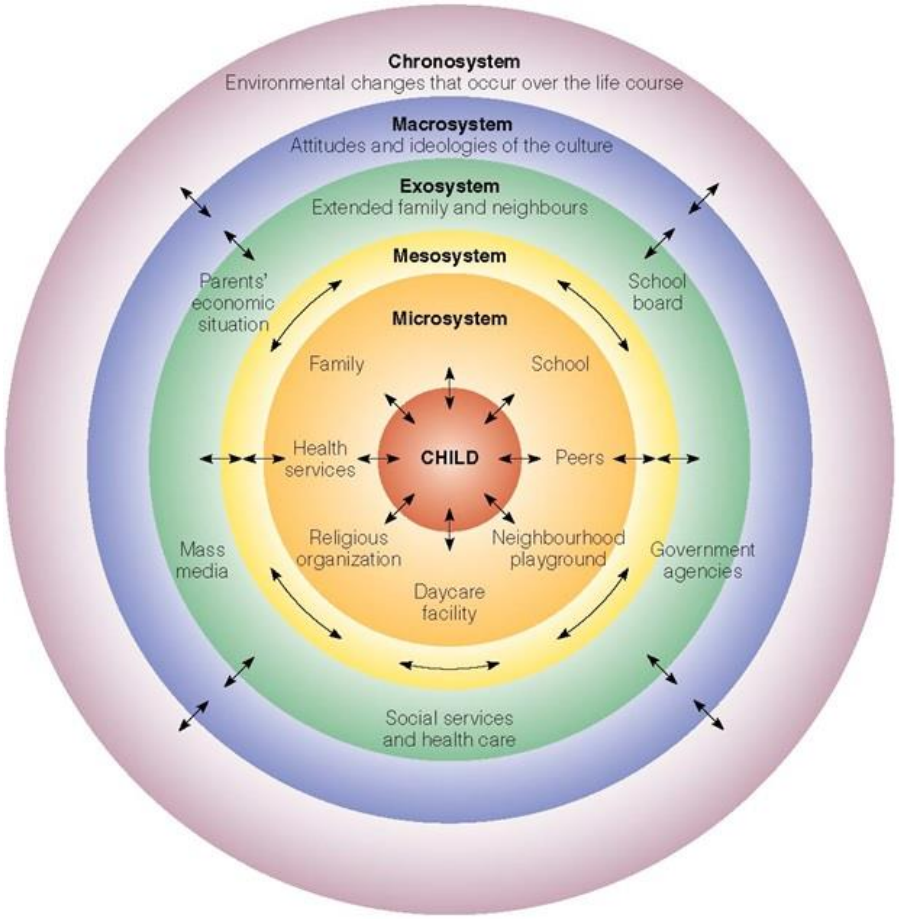
SAMHSA

Ecological Systems

- We learn how to be a mother (parent) in the context of our life

- It's essential to understand the person, from *their* perspective.

- Bronfenbrenner's Ecological Systems Theory



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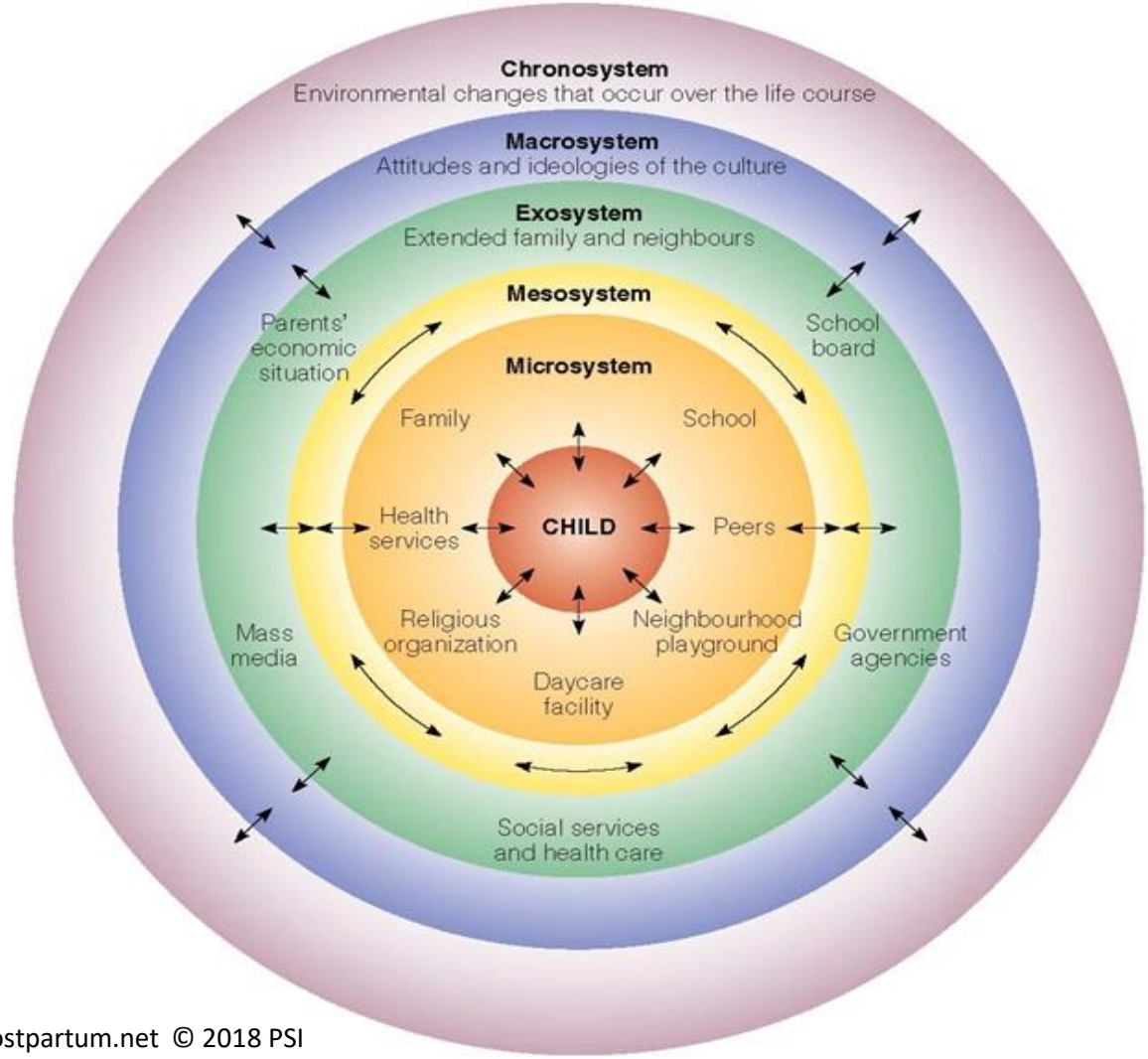


Trauma May Negatively Influence Access to and Engagement in Primary Care:

- Non-adherence or distrust of treatment
- Avoidance of or postponing medical and dental services until things get very bad
- Misuse of medical treatment services – ex. over use of ER Services and misuse of pain meds

SAMHSA's Concept of a Trauma-Informed Approach

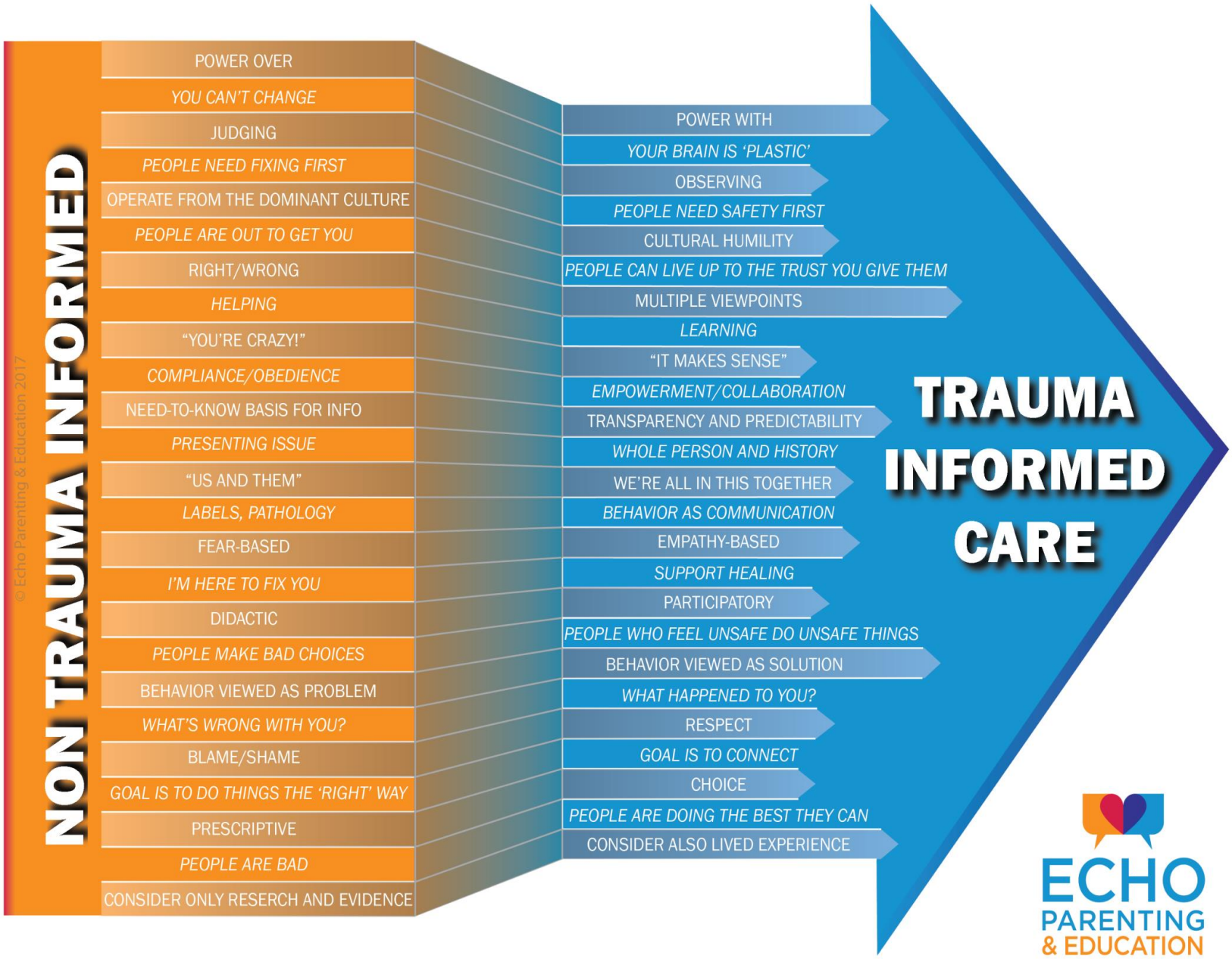
A program, organization or system that is trauma-informed:

(1) ***realizes*** the prevalence of trauma and taking a universal precautions position;

(2) ***recognizes*** how trauma affects all individuals involved with the program, organization, or system, including its own workforce;

(3) ***responds*** by putting this knowledge into practice; and

(4) ***resists*** re-traumatization.


NON TRAUMA INFORMED
POWER OVER
YOU CAN'T CHANGE
JUDGING
PEOPLE NEED FIXING FIRST
OPERATE FROM THE DOMINANT CULTURE
PEOPLE ARE OUT TO GET YOU
RIGHT/WRONG
HELPING
"YOU'RE CRAZY!"
COMPLIANCE/OBEDIENCE
NEED-TO-KNOW BASIS FOR INFO
PRESENTING ISSUE
"US AND THEM"
LABELS, PATHOLOGY
FEAR-BASED
I'M HERE TO FIX YOU
DIDACTIC
PEOPLE MAKE BAD CHOICES
BEHAVIOR VIEWED AS PROBLEM
WHAT'S WRONG WITH YOU?
BLAME/SHAME
GOAL IS TO DO THINGS THE 'RIGHT' WAY
PRESCRIPTIVE
PEOPLE ARE BAD
CONSIDER ONLY RESERCH AND EVIDENCE
POWER WITH
YOUR BRAIN IS 'PLASTIC'
OBSERVING
PEOPLE NEED SAFETY FIRST
CULTURAL HUMILITY
PEOPLE CAN LIVE UP TO THE TRUST YOU GIVE THEM
MULTIPLE VIEWPOINTS
LEARNING
"IT MAKES SENSE"
EMPOWERMENT/COLLABORATION
TRANSPARENCY AND PREDICTABILITY
WHOLE PERSON AND HISTORY
WE'RE ALL IN THIS TOGETHER
BEHAVIOR AS COMMUNICATION
EMPATHY-BASED
SUPPORT HEALING
PARTICIPATORY
PEOPLE WHO FEEL UNSAFE DO UNSAFE THINGS
BEHAVIOR VIEWED AS SOLUTION
WHAT HAPPENED TO YOU?
RESPECT
GOAL IS TO CONNECT
CHOICE
PEOPLE ARE DOING THE BEST THEY CAN
CONSIDER ALSO LIVED EXPERIENCE
TRAUMA INFORMED CARE
© Echo Parenting & Education 2017
ECHO PARENTING & EDUCATION

Resilience is part of Trauma

- J's story
- Group Home Story

- The person coming to you may not know they even had trauma.

- They have been able to survive thus far and that says something.

- Using resiliency and strengths based understanding of the Trauma can be empowering.
  - Victim vs. Survivor

Trauma Informed Care Tools

- Listen
- Education & Training – Understand Trauma and its impact
- Assessments – of self, of clinical environment
- Safety First mentality – promote safety, by example
- Ensuring Cultural Humility
- Supporting Consumer Control, Choice and Autonomy
- Sharing Power and Governance

Trauma Informed Care Tools

- ACES Screening tool
- Urban Aces Questionnaire
- Other screening tools: **Life Event Checklist (LEC)**
  The Abbreviated PCL-C is a **shortened version of the PTSD Checklist – Civilian version (PCL-C)**.
- Establish protocol for positive screens

Resources

- acestoohigh.com
- acesconnection.com
- http://www.philadelphiaaces.org/philadelphia-ace-survey
- samhsa.gov/nctic
- lookthroughtheireyes.org
- chcs.org/project/advancing-trauma-informed-care/
- The Body Keeps the Score – van der Kolk
- Childhood Disrupted – Jackson Nakazawa
- Ghosts from the Nursery – Morse & Wiley
- Ted Talks from Dr Nadine Burke Harris, Dr Allison Jackson, Charles Hunt, Benjamin Perks, John Rigg

Attachment and bonding / Grief and loss – Two sides of the same coin

When does attachment begin?

TO WHOM IS THAT ATTACHMENT CREATED?

DOES THAT ATTACHMENT EVER END?

Before we can talk about the baby, we have to talk about the mother, and her expectations and hopes

- We often don't identify and articulate
  - Our perceptions of motherhood in general
  - Our perceptions of the other mothers in our lives
  - Our perceptions of ourselves as an idealized mother
  - The reconciliation of what we envision and what is real (and what is realistic)
    - Factors within the mother's control
    - Factors in the environment that can be enhanced
    - Drill down and connect with the core motherhood values that matter most
  - When we reconcile what we envision with what is real, and enhance the environment as much as possible, attachment can be optimized

Matrescence

- Alexandra Sacks, MD – “The Birth of a mother” (NYT, May 7, 2017)
  - Also “How come no one told me? The emotional guide to pregnancy and the first year of motherhood” – arriving spring 2019 (with Catherine Birndorf,MD)
- For many moms, once the baby arrives, the focus is on the baby
  - Friends and family lose sight of the mother, and her developmental transition
- Challenges common to this developmental stage
  - Changes in family dynamics
  - Ambivalence
  - Fantasy versus reality/ loss
  - Guilt and shame
  - Competition/ unmet needs

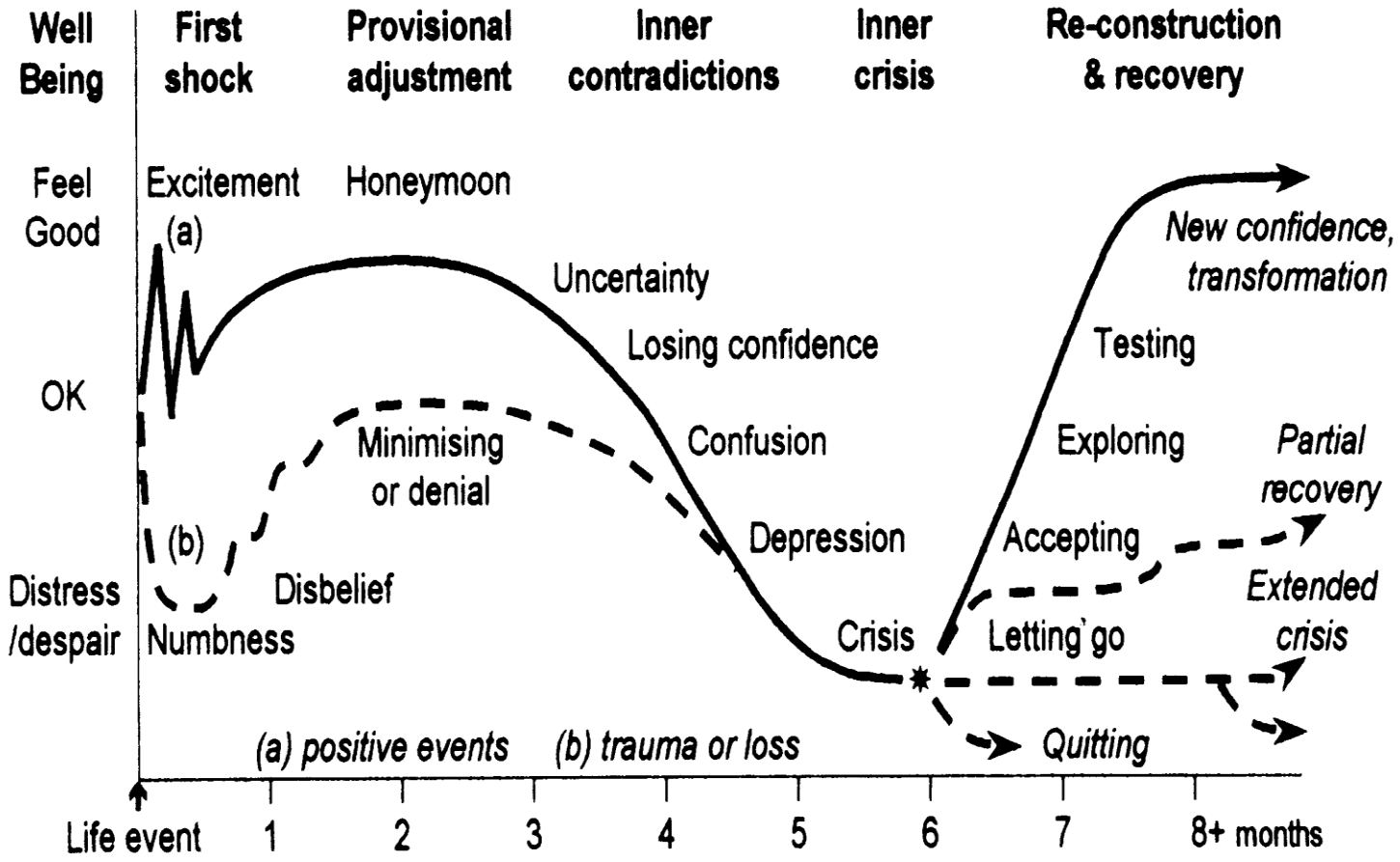
Ambiguous loss is pervasive throughout the transition to motherhood even under the best of circumstances, but especially for those whose experience is complicated by medical issues or other "observable" losses

When you're feeling stuck in your work with a mom,

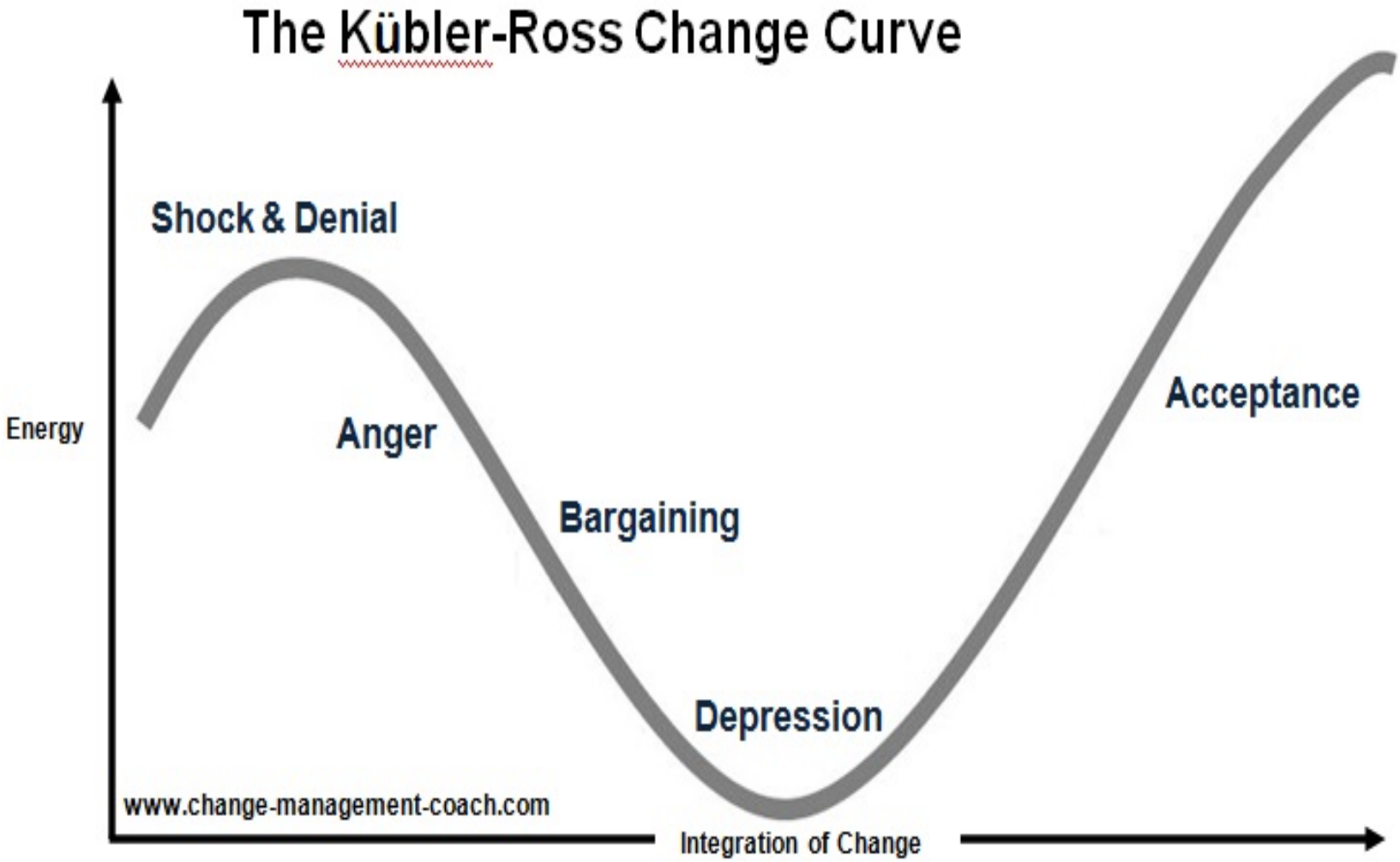
look for what has been lost.

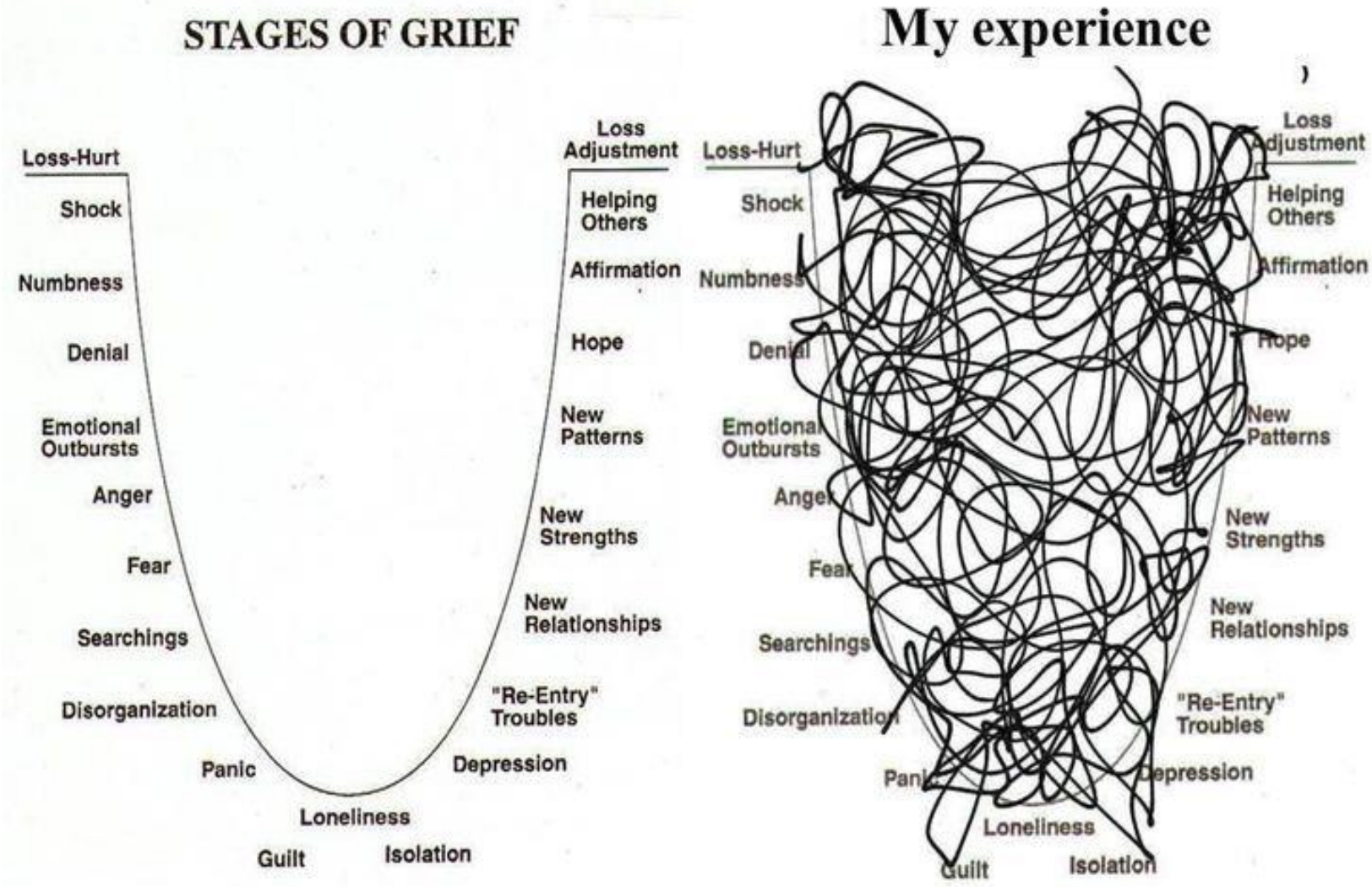
Bereavement models, Psychosocial transitions and the assumptive world

- Colin murray parkes (1970); Colleague of John Bowlby
- Identified the challenge of psychosocial transitions and their challenges to one's assumptive world
- "It includes our interpretation of the past, and our expectation of the future, our plans and our prejudices).
  - Who we are
  - Organizing beliefs
  - Expectations of our daily lives
  - Assumptions of how the world around us works
  - Expectations for predictability in our lives
- * the transition often invalidates our assumptive world – coping with loss/transition means learning to cope with changes in one's assumptive world through a process of rebuilding
- Parkes, CM (1971). Psychosocial transitions: A field for study. *Soc Sci & med (5*), 101-115.



Hopson, B & Adams, J (1976). Transition- Understanding and Personal Change





From Pinterest. Original artist unknown

Working with a mom's assumptive world

- Identify expectations
  - What made those hopes and expectations meaningful for mom?
    - (these are your anchors)
- Acknowledge the discrepancies and disappointments. Let her know that it is safe to share these, even if she worries they are "trivial"
  - What do these discrepancies and disappointments represent to her?
- Through finding the meaning inherent in these hopes, expectations, and disappointments, we can create the building blocks for healing
  - Utilize these themes and values to create meaning within the context of this pregnancy, this baby
  - It may look different, but the foundation will be the same

Infertility

- Affects approximately 1in 8 couples
- Roughly 1/3 a female problem, 1/3 a male problem, 1/3 combined or no known cause
- Losses: ideas of romantic conception, loss of spontaneity in sex life, loss of confidence in bodily function, loss of perception of femininity/masculinity, privacy, genetic connection to child, pregnancy experience, connection with friends building their families, feeling “out of sync”

Infertility - resources

- RESOLVE – www.resolve.org
- American society for reproductive medicine
  - www.asrm.org - professional society
    - MHPG mentorship program
    - Annual conference – Oct 2018, in denver
  - www.reproductivefacts.org - patient resources
- **Books**
  - Infertility counseling (professional resource)
  - Reproductive trauma (professional resource)
  - The infertility workbook
  - Conquering infertility
  - What he can expect when she's not expecting
  - Coping with infertility, miscarriage and pregnancy loss: finding perspective and making meaning

Complicated pregnancy

- 6- 8% of women experience a high risk pregnancy (NIHCD)
- Many more have difficult pregnancy experiences
- Causes
  - Maternal factors
  - Lifestyle factors
  - Fetal factors
  - Pregnancy related factors
- Losses: very similar to those related to infertility – loss of innocence, fear, loss of "typical" pregnancy experiences (shower, "babymoon trip")
- Mom may have many logistical challenges – not able to work, not able to care for older children, bedrest at home, or even hospitalized bedrest
- If the pregnancy results in a healthy baby, these losses are often discounted by friends, family and even the mother herself

- Many moms report guilt, or seemingly search for things they did wrong

Complicated pregnancy - resources

- Hyperemesis gravidarum
  - www.helpher.org
- Parijat Deshpande, MS
  - https://www.parijatdeshpande.com
- Book: High- risk pregnancy: Why me?
- Acts of grace – www.actsofgracefoundation.org

NICU

- 10-15% of all babies (approx 500,000) go to the NICU each year (March of Dimes)
- 40% of NICU moms develop PPD
  - cherry et al (2016) J of multidisciplinary Healthcare
- Up to 70% of NICU parents experience significant symptoms of PTSD
  - As in PPD, dads are more likely to experienced delayed symptoms of PTSD

Challenges of parenting in the NICU

- Separation- whether on a day-to-day basis, or for an extended period of time
- Parental stress, anxiety, fatigue
- Challenges related to infant's health status and appearance
- Hospital setting, rules and policies
- Interaction with hospital staff
- Interactions with family members around hospitalization, medical care, and communication/visitation
- Navigating care for other children
- Balancing hospital stay, parental leave, and return to work
- Financial concerns
- isolation

Emotional complications for NICU parents*

Acute Stress Disorder

- Significant stressor, initial "daze“ and disorientation, followed by symptoms such as depression, anxiety, anger, despair, over activity, withdrawal and diminishes after 24–48 hours

Perinatal Mood Disorders

- Over concern for the baby or excessive anxiety over the infant’s health, guilt , inadequacy, worthlessness, failure at mother hood, fear of losing control, lack of interest in the baby and symptoms continue for weeks or longer following delivery.

PTSD

- Vivid memories related to infant appearance and behavior, pain, procedures, illness severity, and uncertainty of outcomes, traumatic birth experience, PTSD symptoms associated with infant illness severity, Fathers: PTSD more delayed onset, greater risk by 4 mo

NICU challenges continue, even after going home

- Ongoing medical challenges, worries about health stability, return to hospital for appointments, procedures and surgery
- Fear of baby getting sick
- Friends and family often don't "get it"
- Perceived or actual isolation
- Losses: social support, hoped-for postpartum experience, a "normal" baby
  - And guilt for experiencing these emotions when they think (and may be told) they should be grateful that their baby is home

NICU resources

- Intensive parenting – surviving the emotional journey through the nicu
- Parenting your premature baby and child
- Hand to hold – www.handtohold.org
- www.support4nicuparents.org
- Graham's foundation – www.grahamsfoundation.org
- Tangerine owl project – www.tangerineowl.org
- National perinatal association (professional resource)
  - www.nationalperinatal.org

Difficulties in the breastfeeding relationship

- Pressure to be a “good” mother
- For moms who experienced loss, infertility, etc, breastfeeding is often seen as an opportunity for redemption
- For nicu moms, additional pressure to pump/nurse
  - May feel like providing breastmilk is life or death (and this may not be an unrealistic fear)
  - May feel like the only thing they can do for their baby
  - When there are difficulties, it feels like one more domain of failure

Early pregnancy loss

- Up to 1 in 5 pregnancies ends in loss
- Pregnancies are confirmed earlier than ever
- Mom may have not yet even shared the news of the pregnancy
  - Even if she has shared the news, F&F may minimize the loss ("you were only a few weeks pregnant")
- In addition to the obvious loss of her baby, mom may lose confidence her body, feel more anxious during future pregnancies
- Mom may have been shocked to discover she has ambivalent feelings, or even relief, which can then lead to guilt
- In effort to gain control over the situation, mom may look for ways she was at fault

Loss due to fetal or maternal health issues

- These problems have traditionally been discovered mid-pregnancy, but are being discovered at earlier and earlier points in pregnancy
- Whether or not parents continue with the pregnancy, there is
  - Loss
  - Fear of judgment (and perhaps actual judgment)
  - Fear for their baby's wellbeing
  - Fear for themselves, the changes to their lives
  - Guilt
    - "is this my fault?"
    - Over decision-making

Loss of a twin or multiple

- Rates of multiple births increasing, due to IVF and other fertility treatments
- Early loss, or “vanishing twin”
- Loss due to medical intervention/reduction
- Loss near or at delivery (expected or unexpected)
- When a twin passes, mom often ends up on bedrest for the remainder of pregnancy, creating additional losses associated with high risk pregnancies
- Many conflicting emotions – sadness, shock, guilt, relief – and bittersweet happiness for the baby who is born living

Late loss/ stillbirth

- After 20w gestation
- Affects approximately 1% of pregnancies; 24,000 each year (CDC)
- Approximately 11,3000 die within 24 hours of their birth each year
- Problems within the mother, the baby, the placenta/umbilical cord, as well as unknown cause
- Feeling out of control, fear and anxiety in future pregnancy, sense of safety completely violated

Pregnancy loss/ stillbirth resources

- Share foundation – www.nationalshare.org
- Miss foundation – www.missfoundation.org
- Now I lay me down to sleep (photography and photo retouching)
  - www.nilmdts.org
- Still standing – www.stillstandingmag.com
- Return to Zero– www.rtzhope.org
- #ihadamiscarriage Jessica Zucker, PhD- twitter and Instagram
- Books
  - Healing your grieving heart (several books)
  - Unspeakable losses
  - Empty cradle, broken heart
  - Empty arms: coping with miscarriage, stillbirth and infant death
  - Our heartbreaking choices

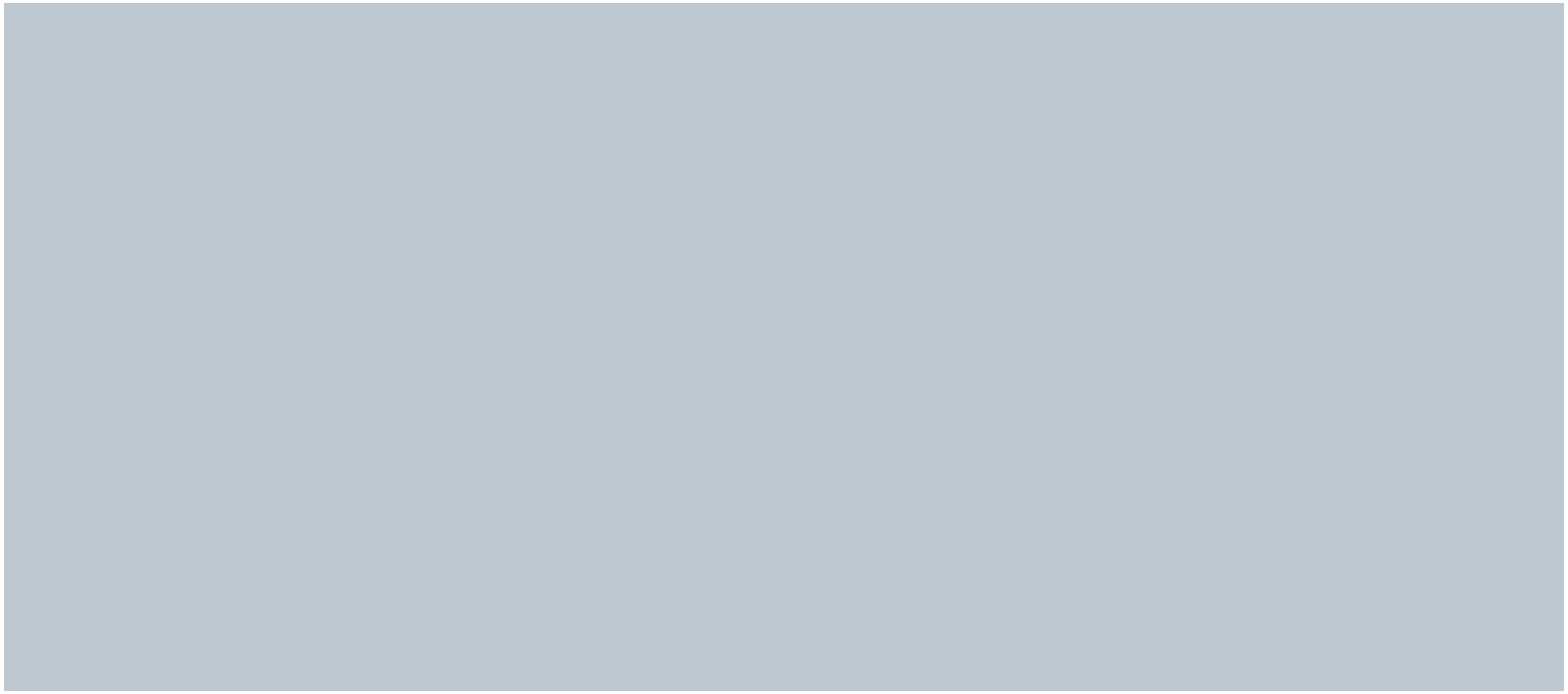
Loss – professional training resources

- Pregnancy loss and infant death alliance – www.plida.org
  - Bi-annual conference: october 2018 in st louis
- Resolve through sharing
  - http://www.resolvethroughsharingonline.org
  - http://www.gundersenhealth.org/resolve-through-sharing/bereavement-training/perinatal-death/
  - http://www.gundersenhealth.org/resolve-through-sharing/bereavement-training/neonatal-pediatric-death/
- Seleni – www.seleni.org
- The shoshana center (deb rich, PhD)
  - http://www.shoshanacenter.com

“shadow” losses

- Gender disappointment
- Multiple pregnancy when a singleton is preferred
- Mistimed pregnancy
- Pregnancy experience different or not as hoped
- Baby’s appearance / resemblance to self or partner
- Temperament
- Not “falling in love” immediately
- Parenting experience not meeting expectations
- Family members not helpful as hoped

Attachment and infant mental health



What is attachment?*

- What is it?
  - emotional relationship that develops between infant and caregiver throughout the first year of life -the child's experience of adult care, from the child's perspective.
- Why is it important?
  - Protects baby from harm
  - Serves to regulate arousal/fear
  - Aids in the development of self-regulation
    - Through repeated interactions with an available adult, the infant's behavior organizers around the caregiver, and the infant develops expectations around that person; these expectations may serve as a framework for future relationships

kara marriott, LCSW and lita simanis, LCSW

The development of self-regulation*

Caregiver regulation

→ Infant participation

→ Dyadic regulation

Guided self regulation

Self regulation

kara marriott, LCSW and lita simanis, LCSW

Patterns of attachment*

- Organized Attachment
  - Secure — Attachment/exploration
  - Anxious Avoidant — Minimizing Strategy
  - Anxious Resistant — Maximizing strategy
- Disorganized Attachment

kara marriott, LCSW and lita simanis, LCSW

Factors that influence attachment

- Caregiver factors
- Infant factors
- Family system factors
- Social context

Supporting attachment

- Mother-baby dyadic Support*
  - All providers can provide mother-baby dyadic support
    - Help caregiver understand infant cues and advocate for baby's needs
  - Reinforce the idea of the good enough parent (Winnicott, 1953; Bettelheim, 1987)
    - Pay attention to baby
    - Provide a holding environment
    - Offer physical and emotional care
    - Provide security
    - Providing repair when necessary
    - Perfection is neither required nor desirable

Mother- infant Therapy (R Clark)

Supporting attachment after loss

- Parents are often surprised that their loss continues to affect them, especially after the year of "Firsts"
- This is **attachment** – the loss of a child does not impact the amount of love felt for their child, or the hopes and dreams they had, merely the amount of time they were able to spend together
- Especially as time passes, F&F may be less understanding of the need to maintain connection. As therapists, we can help families by:
  - Honoring the attachment
  - Helping the family identify meaningful ways to Maintain connection
  - Reassuring them that is this need is not unusual or strange

Infant mental health resources

- World association for infant mental health
  - https://www.waimh.org/i4a/pages/index.cfm?pageid=1
- Zero to three
  - https://www.zerotothree.org
- Handbook of infant mental health, fourth edition

Cultural Humility

Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.

Cultural Humility

- Defined as having an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual's cultural background and experience. (Hook, 2013)

Hook, J.N, Davis, D.E., Owen, J., Worthington, E.L., Utsey, S.O. (2013) Cultural Humility: Measuring Openness to Culturally Diverse Clients. Journal of Counseling Psychology. 60 (3)

- Cultural competency suggests that there is an end to learning, Cultural humility suggests a process that continues.

American Psychological Association. (2003). Guidelines for multicultural education, training, research, practice, and organizational change for psychologists. American Psychologist, 58, 377– 402. doi:10.1037/0003- 066X.58.5.377

Culture is Many things

- Race
- Ethnicity
- Country
- Religion
- Ability
- Affiliation
- Identification
- Gender expansive
- Sexuality

- Neighborhood
- SES
- Native
- Immigrant
- Refugee
- Job status

Intersectionality

- Definition: The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.
  (https://en.oxforddictionaries.com/definition/intersectionality)
- People are many different things
- How do you identify yourself?
- How does someone else identify themselves?
- What is *their* cultural context. We cannot define that for anyone but ourselves.

Racism and Mental Health

- Poorer mental health outcomes

"Chronic exposure to racism may be implicated in hypothalamic-pituitary-adrenal (HPA) axis dysregulation that, in turn, can damage bodily systems and lead to physical outcomes such as CVD and obesity. The impacts of racism on the dysregulation of cognitive-affective regions such as the prefrontal cortex, anterior cingulate cortex, amygdala and thalamus share similarities with pathways leading to anxiety, depression and psychosis"

(Yin Paradies, et al. Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. PLoS One. 2015.)

(Berger M, Sarnyai Z. More than skin deep: Stress neurobiology and mental health consequences of racial discrimination. Stress. 2015;18(1):1–10. doi: 10.3109/10253890.2014.989204)

Microaggressions

- the subtle, stunning and often automatic and non–verbal exchanges which are ‘put downs.

- Types of Micro-aggressions
  - Micro-assault – most like racism, a conscious communication
  - Micro-insult – unconscious communication
  - Micro-invalidation – minimizing or disregarding of feelings/experiences

Sue, D., et.al. 2007. Racial Microaggressions in Everyday Life. American Psychologist, 62(4): 271–286

Disparities

- Maternal Mortality Rates
- Infant Mortality Rates
- Access to health care
- Access in general

Maternal Mortality

- "Each year an estimated 1200 women in the USA suffer complications during pregnancy or childbirth that prove fatal and 60,000 suffer complications that are near-fatal ....."

(WHO, 2015: *Bulletin of the World Health Organization* 2015;93:135. doi: http://dx.doi.org/10.2471/BLT.14.148627)

Maternal Near-Miss Survivors FB closed group

A maternal near miss is an event where a woman nearly dies due to pregnancy or childbirth related complications. The events are often unexpected and may leave the survivor isolated and alone…….

Maternal Mortality

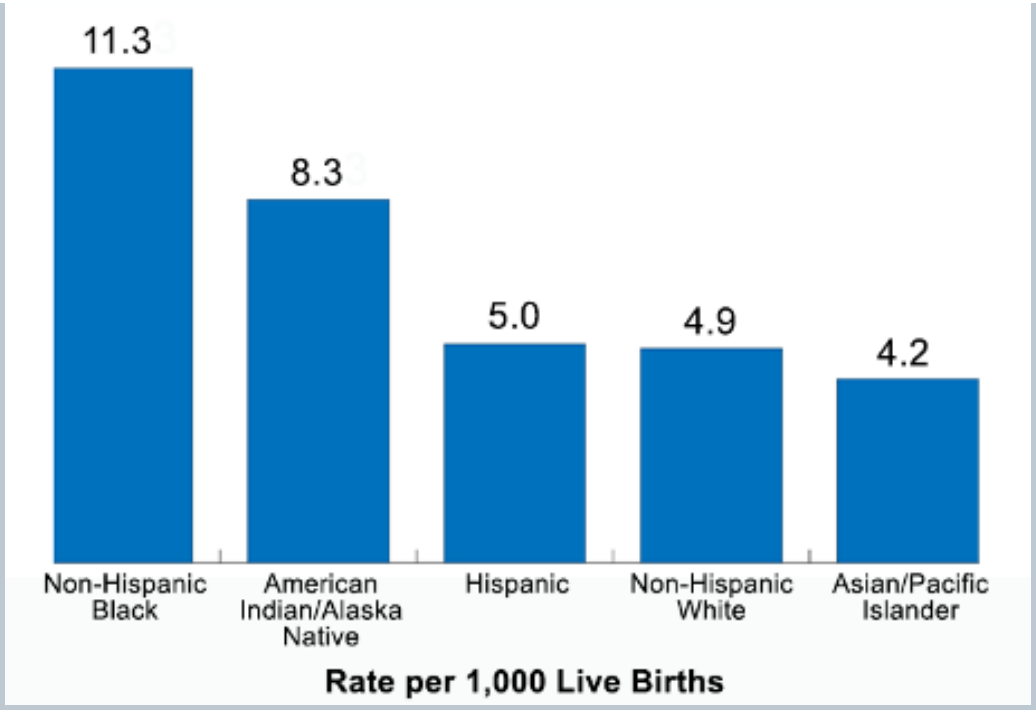
In the United States

- 2011–2013: 2,009 (reported to CDC) were found to be pregnancy-related.

- Considerable racial disparities in pregnancy-related mortality exist. During 2011–2013, the pregnancy-related mortality ratios were–
  - 12.7 deaths per 100,000 live births for white women.
  - 43.5 deaths per 100,000 live births for black women.
  - 14.4 deaths per 100,000 live births for women of other races.

CDC: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

Infant Mortality



CDC: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

Psychotherapy

APA offered 10 Multicultural Guidelines 2017 (adapted):
http://www.apa.org/about/policy/multicultural-guidelines.PDF

- 1 –Identity and Self-Definition are Fluid
- 2 –Recognize your own cultural beliefs, attitudes and perceptions
- 3 – Understand the role of language and communication
- 4 – Be aware of the social and physical environment of clients
- 5 – Recognize historical and contemporary power, privileged and oppression

Psychotherapy

- 6 – Promote culturally adaptive interventions across systems
- 7 – Examine the profession's assumptions and practices in an international context
- 8 – understand how identity evolves through biopsychosocial intersections
- 9 – conduct work in a culturally appropriate way
- 10- strive for a strengths based approach to build resilience and decrease trauma

PSI Bridges the Gap

We provide direct peer support to families, train professionals, and provide a bridge to connect them

www.postpartum.net