TTAC

NYC Early Childhood Mental Health

Training and Technical Assistance Center

Pregnancy as a Time of Hope and Fear Exploring the Biological, Emotional, and Social Dimensions of the Perinatal Period

Presented by Dr. Alicia Lieberman

Who We Are

The New York City Early Childhood Mental Health Training and Technical Assistance Center (TTAC), is funded by the NYC Department of Health and Mental Hygiene (DOHMH)

TTAC is a partnership between the New York Center for Child Development (NYCCD) and the McSilver Institute on Poverty Policy and Research

- **New York Center for Child Development** has been a major provider of early childhood mental health services in New York with expertise in informing policy and supporting the field of Early Childhood Mental Health through training and direct practice
- **NYU McSilver Institute for Poverty Policy and Research** houses PeerTAC and the Community and the Managed Care Technical Assistance Centers (CTAC/MCTAC), which offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers

TTAC is tasked with building the capacity and competencies of mental health and early childhood professionals through ongoing training and technical assistance
http://www.TTACny.org

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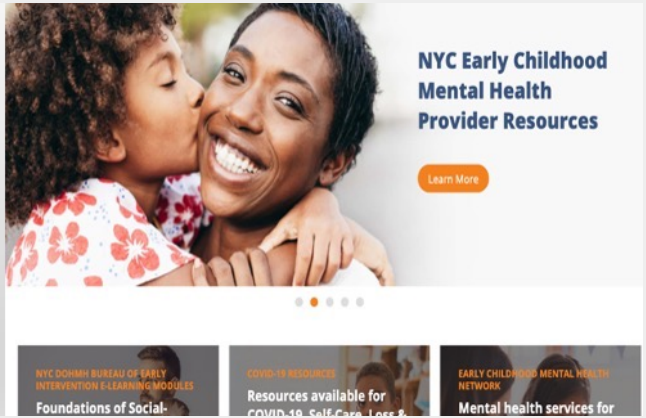
Updated TTAC Website

Explore all the provider resources at ttacny.org



A Selection of Features:

- Seamlessly filter, toggle and search through upcoming and archived content, trainings and resources
- View videos, slides, and presenter information on the same training page
- Contact the TTAC team by clicking on Ask TTAC and filling out our Contact Us form
- And more!

Have questions or need assistance? Please contact us at **ttac.info@nyu.edu** and we'll be happy to assist you

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TTAC Infant and Early Childhood Mental Health (IECMH) Learning Modules are now live!

Two Learning Modules:

- The first module in the series is**the Impact of Early Childhood Adversity (An Overview of the Topic)**
- The second module in the series is **Nurturing Resilience: Supporting Infant and Early Childhood Mental Health**
- CEUs Available upon completion!

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Pregnancy as a Time of Hope and Fear

Exploring the Biological, Emotional, and Social Dimensions of the Perinatal Period

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PERINATAL ChildParent Psychotherapy

Pregnancy as a Time of Transformation:

Body, Mind, Identity

A Developmental Psychopathology Perspective: Protective and Risk Factors

- Personal strengths and stresses

--Physiological processes

--Psychological transformations

--Changes in intimate partner relationship

--Changes in extended family relationships

-- Changes in social roles

- Sociological realities

-- Maternal mortality in the U. S. doubled in last 30 years and COVID compounds risks

-- Disproportionate increase in URM groups

-- Exponentially higher mortality rate in Black mothers and Black babies

-- Insufficient social and governmental support for new mothers and fathers

-- Destructive impact of legal attacks on reproductive freedom that deprive women of choice

Pregnancy Changes in the Body

- **For the pregnant woman**

-- Anatomical y physiological changes to nurture and accommodate the developing fetus and prepare the mother for labor and delivery

-- Every organ system of the body is involved, including the senses

-- High levels of 10 pregnancy-related hormones influence mood

-- Weight gain increases body workload from any physical activity

- **For fathers-to-be**

-- Hormonal changes show shift from motivation to mate to motivation to nurture: Decreases in testosterone, increases in prolactin and oxytocin

-- Biological changes persist after the baby's birth

-- Weight gain, BMI increases

-- Mood changes, symptoms that mimic pregnancy (nausea, decreased sleep, food cravings, digestive changes)

A Time of Personal Transition: Psychological Transformations During Pregnancy

- **For the pregnant woman**

  -- Increased vulnerability and fear of losing control over her life
  -- Realistic anticipatory anxiety about childbirth: Body damage and survival
  -- Reemergence of unresolved childhood conflicts: Fears of loss, losing love, body damage, personal worth
  -- Reworking of relationship with mother's mother and father
  -- Accepting and incorporating the fetus into her body and sense of self

- **For the father-to-be**

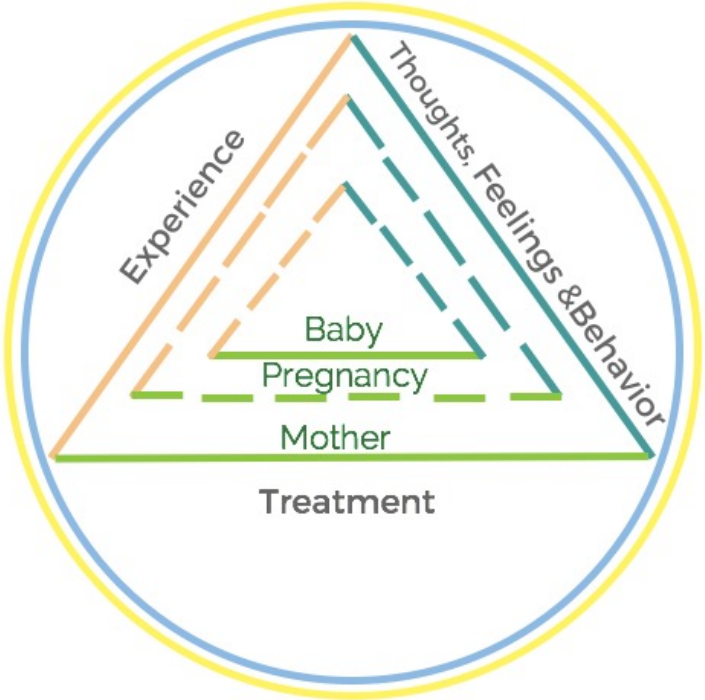
  -- Innate desire to nurture: "Genuine fatherliness"
  -- Greater influence of social and cultural role expectations over biology
  -- Fluidity in gender roles and individual choice blur biology-culture boundaries
  -- Frequent exclusion from systems of care generates a sense of being superfluous and unneeded
  e.g., "maternal and child health" versus "maternal, paternal, and child health" or "family health"

A Time of Interpersonal Transitions:
Relationship Changes with the Intimate Partner and Family of Origin

- **Changes in the intimate partner relationship (IPR)**
  -- How safe, stable, and secure in the IPR?
  -- Was the pregnancy planned? (45% unplanned/year; 18% of these "unwanted")
  -- Is the pregnancy wanted by both partners?
  -- How does each of the IPs navigate economic, social, sexual expectations?
  -- Is there agreement about how the baby will be raised?

- **Changes in the extended family relationship**
  -- How family of origin responds may help resolve or exacerbate personal conflicts
  -- Do the families of origin for mother and father welcome or judge the pregnancy?
  -- Are members of the family of origin physically and emotionally available?
  -- Do members of the family of origin have material and emotional resources to be of help?

Evolving a Coherent Identity as a Mother: Permeable Membranes between Self, Body, Baby



Evolving a Coherent Identity as a Parent and Co-Parent

- Growing love for the unborn baby supports identity as a parent as a salient new aspect of one's self-definition
- Reconciling the demands of multiple roles and giving priority to different roles depending on overarching need
- Each pregnancy is different because the circumstances are different for each pregnancy
- Over-riding concerns during pregnancy and post-partum:
  -- "Can I do it all?"
  -- Can I remain true to myself while being a good parent?
  -- Can I be a better mother than my mother? Better father than my father?
  -- Accepting "normal parental ambivalence":
  -- Emotional maturity in embracing being "good enough parent"
  -- Are IPs present and supportive? Absent? Antagonistic? Violent? Competitive? Blaming each other?

Concrete Expressions of Emotional Bond with the Fetus: Keeping the Baby in Mind

- Heightened sensitivity to fetal/infant wellbeing in daily life and plans

- Self/Fetus care behaviors: Eating well, avoiding harmful substances

- Affectionate behaviors: caressing belly, talking to the fetus/infant

- Nesting behaviors: preparing the home by making a physical space for the baby, buying clothes and equipment

Maternal Mental Health:
Confluence of Social Inequity and Individual Factors

- Maternal MH conditions affect up to 1 in 5 American women in pregnancy/peripartum each year
- Psychiatric conditions are the most frequent complication of pregnancy and childbirth
- Substance use and suicide are among the leading causes of death postpartum
- 4/5 of maternal deaths are preventable
- Racial inequities are stark: A college-educated Black woman is 60% more likely to die in the perinatal period than a While woman with less than a high school education.
- Black babies were 3 times more likely to die when delivered by a White doctor than by a Black doctor in a study of 1.8 million hospital births in Florida between 1992-2015. White babies' survival was unaffected by the doctor's race (PNAS, 2020).

(CDC, 2022; Commonwealth Fund, 2020)

BE SAFE STUDY
Intersectionality of Poverty, URM Status, and Risk

- N= 101 pregnant women receiving prenatal care at ZFGH
- Economic status: 62% below federal poverty line
- Race/Ethnicity: 37% Latina, 22% Black, 20% White, 21% Multiracial
- ACEs: M=4.08; SD=2.67; Range: 0-10

  -- 55% reported 4+ ACEs; 32% reported 6+ ACEs
- Unplanned pregnancy: 62%; Lifetime unwanted pregnancy: 44%
- Lifetime IPV: 56%; Pregnancy IPV: 14% (20% enacting IPV)
- Clinical Depression: 47% PTSD: 29% Co-Morbidity: 24%
- "Unmet needs": 50% No mental health services: 67%

(Narayan et al., 2017)

Impact on Babies of Maternal Risk Factors

- "Fetal Programming"

  Prenatal maternal stress is linked to alterations in fetal development

  -- Placental-fetal stress physiology

  -- Newborn brain structure

  -- Respiratory Sinus arrhythmia (RSA), marker of self-regulation

  -- Long-term risk for psychiatric conditions
- Impact of unplanned/unwanted pregnancy and IPV on infant outcomes

Intergenerational Transmission of Trauma

- Women with histories of child maltreatment and IPV are more likely to experience postpartum depression
- Women with histories of childhood trauma show increased comorbidity of postpartum depression and PTSD
- These mothers are more likely to engage in child abuse
- Their babies more likely to have poor perinatal outcomes

The Impact of Intimate Partner Violence

- **On the woman**

  -- Medical complications: UTI, preeclampsia, anemia, kidney infections, placental abruption, hemorrhage

  -- Brain injury from blows to the head; oxygen deprivation from chocking

  -- Delayed prenatal care; unwanted pregnancies

  -- Substance use

  -- Femicide

- **On the baby**

  -- Low birthweight; preterm birth; increased NICU and hospitalizations

  -- More health problems, including infections

  -- Abuse and neglect, with mortality highest in first months of life

Breaking the Transmission of Parental Pain to Babies: No Discipline Can Do It Alone

Creating interdisciplinary system collaborations:

- **Family planning:** Birth control preferences and options
- **OB/GYN:** Prenatal care, Labor and Delivery, Post Partum Unit
- **Primary Care:** NICU, Pediatrics, Family Medicine
- **Family Resource Programs:** Concrete assistance
- **Mental Health Services:** P-CPP, Co-PCPP; Adult Psychiatry

Mental Health-Primary Care Collaboration

The Perinatal Child-Parent Psychotherapy (P-CPP) Model

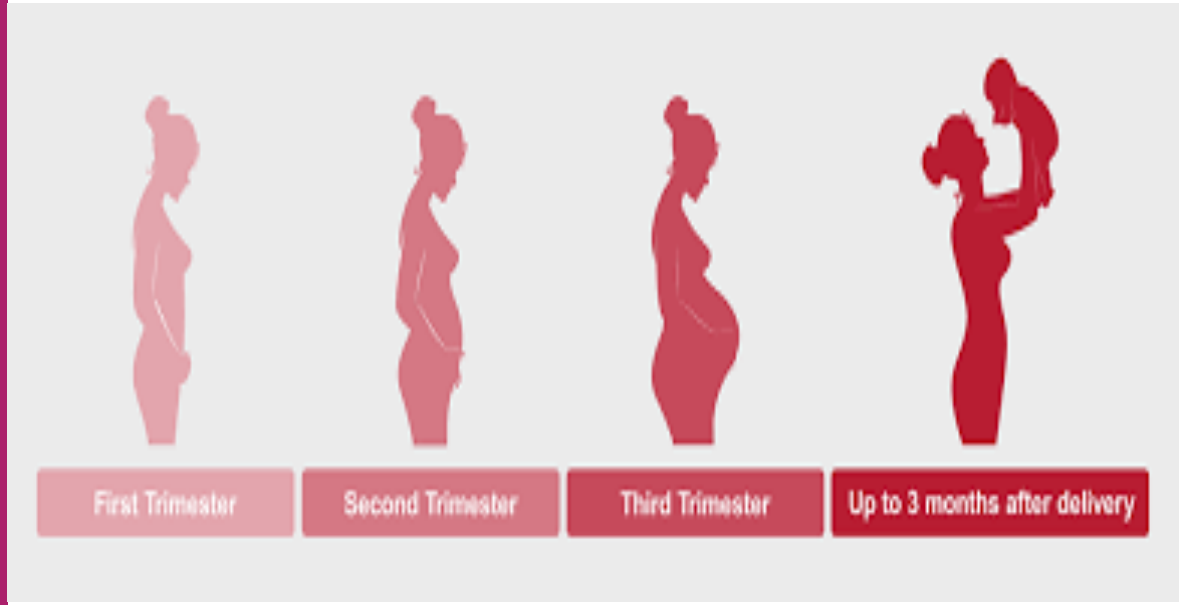
- Weekly check-in with social workers in the ZSFG Women's Clinic
- On-site presence at ZSFG OB Psych
- On-site mental health consultation
  - --Labor and Delivery
  - --Post Partum Unit
  - --NICU
  - --Pediatrics
- Referral for P-CPP when intensive intervention is clinically indicated

Perinatal Child-Parent Psychotherapy (P-CPP) Integrating Prevention and Treatment

- Two-Generation Multi-theoretical, Integrative Approach:
  - Developmental, Multicultural
  - Psychodynamic, Attachment, Trauma, CBT, Body-Informed, Reality needs
- Therapeutic focus:
  - Psychogenic beliefs, distorted perceptions, negative attributions
- Relationship-based, Family-focused
  - Attention to impact of past adversity and relational experiences on current mental health and family relationships

TREATMENT PHASES

Perinatal Child-Parent Psychotherapy



Perinatal Child-Parent Psychotherapy (P-CPP) Integrating Treatment and Prevention

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P-CPP Format: Foundational Phase

Assessment and Engagement: 3-5 sessions

- Who are we working with?

--Current circumstances: Safety? Danger? Violence?

--Pregnancy: How it happened and its meaning

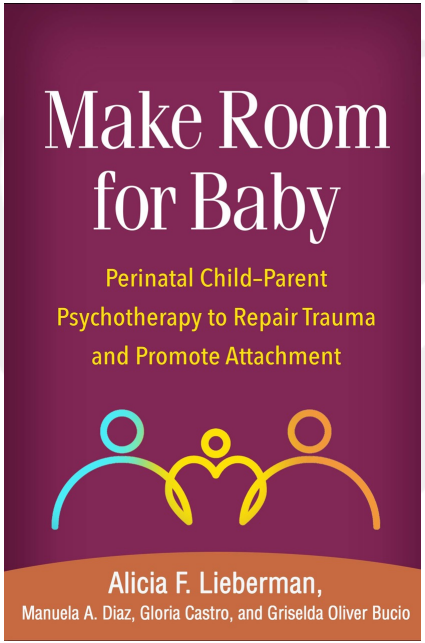
--Ghosts in the Nursery: Adversity and Trauma

--Angels in the Nursery: Strengths and Hope

- Case Formulation & Feedback: Treatment plan

  --Establishing priorities

  --Who will participate



Core Treatment: Exploring Maternal and Paternal Attributions

- Back and forth between present, immediate past, and childhood loneliness, fear and rage: Seeking the emotional meaning of **specific** memories and fears

- "I always had this fear that I would squish a little puppy or a little kitten, or a baby, squish them real hard and kill them. I've always been scared of that impulse. I am terrified I will do that to my baby".

- "And you want to protect the baby from that impulse you fear so much"

Creating a Culturally Informed Birth Plan: Practicalities and Emotions

- Supporting pregnant woman to anticipate and prepare
  -- Asking what to expect, requesting what she needs
  -- What she will need at the hospital for herself and the baby (Childbirth kit)
  -- Who will bring her to the hospital
  -- Who will care for older children
  -- At the hospital: Who will be with her
  -- Who will help at home after discharge
  -- What the baby will need at home
  -- OB checkup and pediatric care

Childbirth and Meeting the Baby

- Childbirth as a life-or-death experience: How was the experience?

- Baby as individual

  How do the mother and father perceive the baby? Do they agree? Disagree? Rejoice? Reject?

  "He is a prince"; "He cries too much"; "She sucks too hard and hurts my nipple"

- Enlisting coping skills and external help

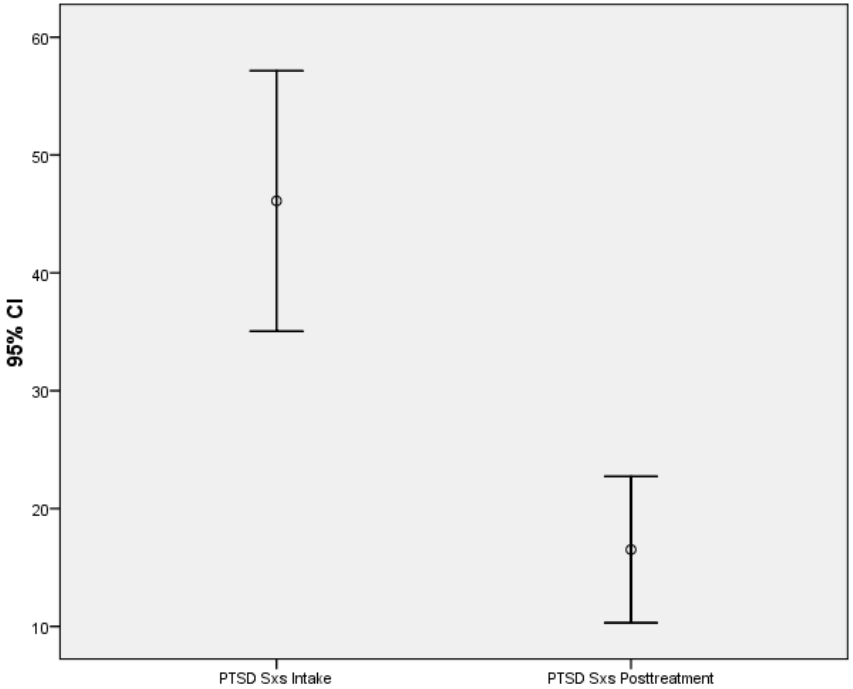
  "I can't feed her when I need to eat myself because I get too angry, but my mother helps me"

- Integrating separate agendas: Tolerating ambivalence

  "I want to leave her on the steps of a church"

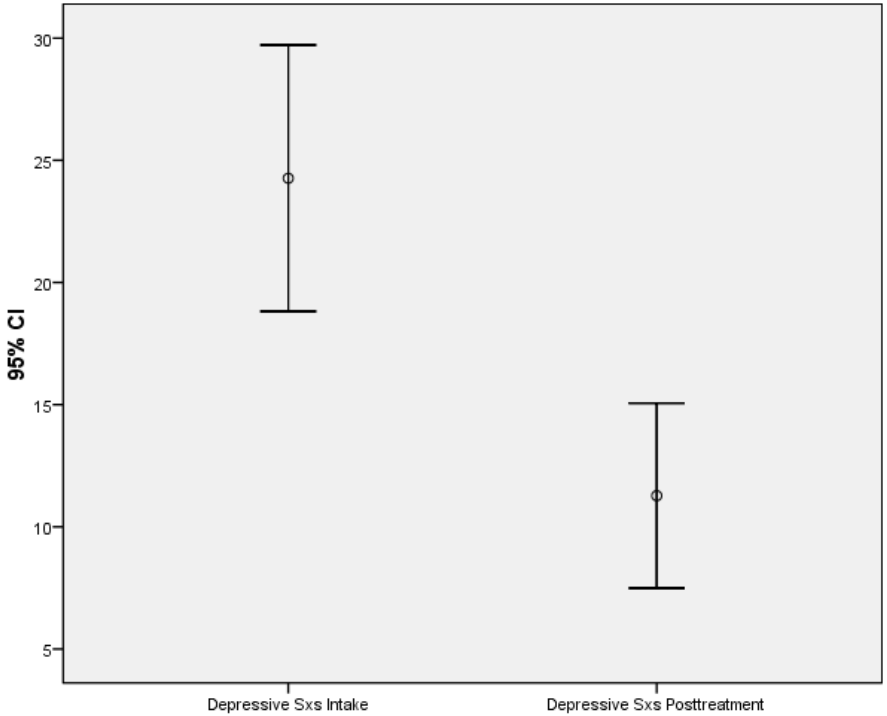
  "I need to do my own thing, but can she manage without me?"

P-CPP Outcomes
Maternal PTSD Symptoms



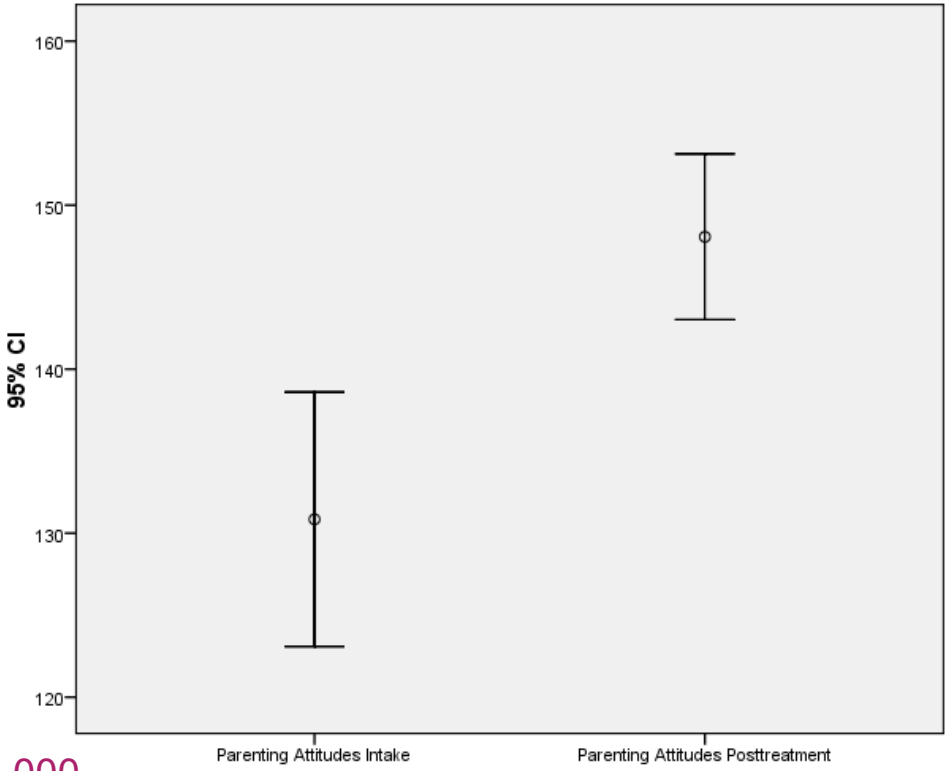
DTS: $F(1, 28)=22.88$, $p=.000$ **N= 114**

P-CPP Outcomes
Maternal Depressive Symptoms



CES-D: $F(1, 28)=13.49$, $p=.001$ **N=114**

P-CPP Outcomes
Parenting Beliefs and Attitudes



F(1, 30)=48.30, *p*=.000

Lessons Learned, Message Offered

- The perinatal period is a key opportunity to pursue social justice in mental health services
- Address convergence of psychological challenges and social disparities
- Best practice calls for collaboration between primary care and mental health
- Integrative, culturally attuned, family-oriented services can repair trauma and prevent its intergenerational transmission