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Perinatal Child–Parent Psychotherapy for Newborns and Mothers Exposed to Domestic Violence

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The period immediately after birth is a transformative time for the baby and for the parents. Mothers and fathers report profound changes in their sense of themselves and their relationship in response to pregnancy and their baby’s birth (see Cohen & Slade, 2000, for a review). Yet how does one imagine the infant’s experience? The apt term labor applies not only to the mother but also to the child, who is compelled by powerful biological forces to depart from the secure confines of the maternal womb and to push pain-takingly through the birth canal before emerging to confront a world utterly different from the womb and filled with unfamiliar tactile, kinetic, visual, and auditory stimuli. This “new baby” is, however, anything but new. Newborns are profoundly shaped not only by genetic and other biological influences but also by the context in which they grew as a fetus: both the intrauterine environment of their mother’s body and the physical and social environment of their parents and community. What happens when the environmental conditions are not conducive to emotional health for the mother and the infant?

Domestic Violence During Pregnancy

A pregnant woman has a 35.6% greater risk of being a victim of violence than a nonpregnant woman (Gelles, 1998). Berry Brazelton wisely identified pregnancy as the first “touchpoint,” or predictable crisis, in development (Brazelton, 1992). The first adaptations to the environment take place in utero, where the fetus reacts to stimulation through responses that are stored in memory and continue to shape behavior following the baby’s birth (Gopnik, Meltzoff, & Kuhl, 1999). When the pregnant woman’s well-being is shattered by traumatic experiences, the consequences are harmful for both the woman and the fetus. The prevalence of domestic violence (DV) is similar to medical conditions routinely screened for in the mother, such as gestational diabetes and preeclampsia, with health consequences that include maternal low weight gain, hemorrhage, infections, anemia, predelivery hospitalization, and Cesarean sections; for the baby, DV gestational exposure is associated with infant prematurity, low birth weight, excessive crying, feeding and sleeping problems, and susceptibility to infectious diseases (Coker, Sanderson, & Dong, 2004; Gazmararian et al., 1996; Jasinski, 2004).

DV also affects the mother–infant relationship: Battered women have greater difficulty bonding with their infants and engage in higher rates of punitive parenting and child abuse, with minority mothers being particularly vulnerable because of their more adverse socioeconomic circumstances and less access to resources (Osofsky, 1995; Roberts, 2002). For example, one representative study of low-income pregnant Latinas found that up to 80% of respondents reported being shaken, pushed, shoved, or slapped on the face and head; 30% were verbally threatened with death; and 18% were actually threatened with a knife or gun (Wilst & McFarlane, 1998). Dangers to the baby’s physical safety continue beyond the perinatal period because different sources of violence tend to coexist, with an estimated 50%–70% overlap between DV and child abuse (Kitzmann, Gaylord, Holt, & Kenny, 2003).

In light of these findings, it should not be surprising that 44% of child abuse mortalities occur during the first year of the baby’s life, and one third of maltreated infants under age 1 are injured during their first week of life (Child Welfare Information Gateway, 2008). DV-exposed infants may be more difficult to care for because of their greater irritability, feeding and sleeping problems, and susceptibility to illness. Battered women and their violent partners often lack the personal resources to face these parenting challenges. Child abuse is often the result of parental and child vulnerabilities in collision with one another.

An Interdisciplinary Treatment Model

Addressing the nexus between maternal and child safety and well-being in DV situations calls for coordination of services across health care.

Abstract

Pregnancy is a time of heightened risk for domestic violence and of increased vulnerability to traumatic events. In this article, the authors explain how the experience of domestic violence during pregnancy threatens the newborn’s healthy development as well as the parent–child relationship. San Francisco General Hospital’s Perinatal Child–Parent Psychotherapy (Perinatal CPP) is an intervention designed to promote physical and emotional safety during gestation and the first year of life.
A pregnant woman has a 35.6% greater risk of being a victim of violence than a nonpregnant woman.

providers. The San Francisco General Hospital (SFGH) is well positioned to support such a model because, as the trauma center for northern California, it provides treatment to primarily underserved, low-income, and minority groups with a high prevalence of exposure to accidental injuries, community violence, family violence, and other adversities associated with lack of access to basic resources. At the Ob-Gyn Department, 60% of the obstetrical patients are low-income, unacculturated Latinas, with an average of less than 5 years of residence in the United States; all receive Medi-Cal for perinatal care. Preventive and intervention services for them and their babies are severely limited by the scarcity of linguistically and culturally competent service providers. The SFGH Women’s Health Center offers two support groups in English and Spanish for pregnant women in violent relationships, but this service is insufficient to meet the high demand and address the clinical complexity of the cases seen at the clinic.

To address these needs, the Child Trauma Research Program (CTRP) launched a model of collaboration linking trauma-trained infant mental health providers, the Ob-Gyn Women’s Health Center, and the Department of Pediatrics. The social worker at the Women’s Health Center systemically asks pregnant women coming for prenatal care about life adversities and about their frame of mind, probing for exposure to domestic violence or other traumatic stressors. When a woman reports experiencing stress or violence with her partner, the social worker gives her a brief description of CTRP mental health services and asks whether the CTRP clinician can meet her at the next prenatal care visit. If the mother agrees, the CTRP clinician meets the woman at the clinic to tell her about pregnancy as an important time to care for herself—both physically and emotionally—to provide a good beginning for her baby and offers weekly counseling meetings through pregnancy, delivery, and until the baby is at least 6 months old. Perinatal Child-Parent Psychotherapy (CPP) represents an extension into pregnancy of Child-Parent Psychotherapy, a trauma-focused treatment for children in the birth-to-5-year-old age range that involves meeting with parent and child jointly and using play, caregiving routines, and spontaneous interactions as the basis to build safety and restore reciprocity (Lieberman & Van Horn, 2008).

The first lesson learned in implementing this model is that the women attending the SFGH Women’s Health Center suffer from pervasive exposure to violence but frequently minimize it when first asked about it. This finding led us to make the violence screening more responsive to the women’s need to establish trust before risking disclosure. The intake procedure now moves gradually from asking about verbal disagreements and stressful exchanges to asking about concrete acts of physical aggression. The disclosure of physical violence increased considerably following this procedural change. Perhaps the reason is that the socially abhorrent concept of domestic violence does not always fit with a woman’s self-concept or image of her partner. One woman summarized this understanding when she said, “He hits me, but he is not violent.” For her, the word vio-

lence evoked TV-like images of lethality that were not matched by her perception of her own experience.

For many mothers immigrating from countries torn by war and social dislocation, what happens to them in their intimate relationship is negligible compared with the atrocities in their communities of origin. For other mothers, physical and emotional abuse began in their childhoods and became so chronic and pervasive that violence became an expected if dreaded ingredient of everyday life. The consequences of these cumulative adversities are stark. Nearly half (46.7%) of the women in our sample experience pregnancy complications such as hypertension, and about 70% endorse significant symptoms of depression and traumatic stress. The women are often relieved when the clinician normalizes their experience by linking their physical and emotional symptoms to the stress of their adverse socioeconomic circumstances and more specifically to their fear of their partners’ violence. This new understanding is an important first step in building a therapeutic alliance.

DV perpetrated by the woman was an unexpected early finding as we implemented the treatment model. Approximately 30% of the women reported that they engaged in physical violence against their partners by slapping, shoving, or throwing objects at them. Use of knives, guns, or other lethal objects was infrequent, but a few women reported engaging in violence that led to their partners’ severe injury and hospitalization. This finding underscores the importance of assessing and treating maternal and mutual violence when working with battered women and their infants.

DV exposure is also indirectly related to the mothers’ use of the emergency room rather than regular pediatric appointments for their infants’ care, resulting in less appropriate pediatric care and posing a burden for the increasingly stressed public health system. When asked about their reasons for choosing the emergency room, the mothers said that they associate the need for medical care with serious health problems and often avoid regular contacts with the medical system for fear of legal problems either because of being undocumented or because of medical reports of family violence. Other factors include unfamiliarity with the U.S. health care system, leading to frequent misunderstandings between mothers and pediatric providers. For example, some mothers worried that vaccinations could cause AIDS or that bringing a healthy baby to the pediatric clinic could make him sick from exposure to pathogens.

Many mothers believed that their pediatric providers discriminated against them by not offering the treatment expected by the mother (e.g., by not prescribing antibiotics
to treat a baby's cold). The health providers, in turn, voiced negative perceptions of many mothers. Although SFCH medical providers are justly renowned for their commitment to underserved populations, many of them thought that the mothers were neglectful when they did not comply with medical recommendations. We understood from the early implementation stage that CTRP clinicians, who belong to a range of cultural/ethnic groups and many of whom are bilingual in Spanish, could serve as effective cultural mediators between the mothers and pediatric care providers. To fulfill this function, clinicians learned to take the time to understand the specifics of mutual misconceptions and to frame them in a cultural context that avoids blaming either the parent or the pediatric care providers. Active engagement in promoting well baby care became an integral component of our intervention as a result of this experience.

**Perinatal Child–Parent Psychotherapy**

Perinatal CPP employs a range of therapeutic modalities to address maternal emotional problems and to promote the mother–infant relationships both during pregnancy and after the baby's birth. These modalities include: (a) psychoeducation about the impact of domestic violence and life adversities on the pregnant woman's and baby's physical and emotional well-being; (b) developmental guidance about pregnancy, delivery, and parenting during the perinatal period and the first months of the baby's life; (c) insight-oriented interventions that link current emotional states to early experiences and present traumatic triggers, with a dual emphasis on elucidating the "ghosts in the nursery" that interfere with the mother's emotional claim on the baby (Fraiberg, 1980) and on retrieving loving early memories that can serve as "angels in the nursery" that guide the mother's plans for how to care for her child (Lieberman, Padron, Van Horn, & Harris, 2005); (d) body-based interventions that direct attention to bodily sensations and promote relaxation and self-care, including mindfulness-oriented techniques; and (e) concrete assistance with problems of living, including crisis intervention (Lieberman & Van Horn, 2005). The content and format of the therapy sessions are structured to provide appropriate support and guidance as the pregnant woman transitions to motherhood. Both during pregnancy and after childbirth, interventions are consistently geared to helping the mother make connections between her own experiences and how these experiences influence her attitudes and feelings toward the baby. The clinical example below provides an illustration of perinatal CPP.

Estela, a 34-year-old Salvadoran immigrant in the seventh month of pregnancy, was referred for treatment by her Women's Health Center social worker because of her DV history both as perpetrator and victim. Estela was prone to explosive outbursts of anger, directed mainly toward her partner of 8 years. During the last violent episode 2 months earlier, Estela reported throwing household objects at her partner, who was hospitalized with lacerations to the head, face, and arms. She was jailed but released when the partner failed to press charges. Estela said that her partner had also been violent toward her but was now voluntarily attending an anger management class because he worried about the baby's safety if violence continued. At the time of referral, Estela was experiencing pregnancy complications consisting of vaginal bleeding and early contractions. She was also taking antidepressants.

During the initial assessment, Estela described an extensive history of childhood trauma, including repeated physical abuse and an incident of sexual abuse at age 5 that occurred when her own mother was inebriated and masturbating while asking Estela to touch the mother's genitals. This information suggested that Estela's violence toward her partner might be an expression of her early rage at her mother's violation. She was likely to have unconsiously equated her partner with her mother, who had been her first sexual partner and someone whom she loved but also perceived as frightening and exploitive. Estela's violence toward her partner could be understood as an effort to protect herself in the present from the physical violations and unbound sexual and aggressive feelings that had overwhelmed her as a little girl.

Estela also reported growing up in a chaotic family where, in her words, physical aggression "occurred pretty much all the time" and "everything was resolved with punches." When she was 13, Estela and her siblings were sent to live with her maternal grandmother, who used harsh corporal punishment with the children. Adverse childhood experiences included chronic DV exposure, repeated and severe physical abuse, an episode of maternal sexual abuse, and exposure to the violence and devastation of a war-torn country, including seeing murdered peasants by the side of the road. Estela's scores on structured diagnostic instruments revealed elevated levels of posttraumatic stress disorder and depression symptoms.

Estela's pregnancy provided reasons for hope in this bleak overall picture. She stated that this pregnancy was "a miracle" because she thought that she would never conceive again after seven miscarriages during the past 5 years. She also reported a strong emotional connection with her unborn baby, a statement corroborated by her commitment to treatment and her eagerness to learn about becoming a responsive mother. Estela and her baby participated in Perinatal CPP sessions until the infant was 8 months old.

**Validating Early Feelings and Creating New Memories**

During the initial treatment phase, Estela described feeling alone and betrayed both by the sexual abuse and the lack of care from her mother, who she said was "never there" when Estela "needed her the most." Tearful and with a mixture of sadness and rage, she gave detailed accounts of incidents when the mother was "too drunk" to care for her and her younger siblings. As the oldest of five children, Estela remembered having to bathe and cook for her younger siblings from an early age. This caretaking role continued after she and her siblings started living with their grandmother.

The clinician endeavored to help Estela understand the difference between remembering her early experiences of abuse and reliving them by reenacting them in the present when she misconstrued conflicts with her partner as a signal of imminent danger to herself. Estela gradually learned to link her current rage and distress to memories of how she felt when she was abused by her parents. When her partner's behavior reawakened early memories of being abused, she exploded with rage and became uncontrollably aggressive as a way of fending off internal states of terror and helplessness. Estela expressed profound relief when she came to understand that she had learned to resort to physical aggression as a means of self-protection because she always felt deeply ashamed of her aggression and thought of herself as "crazy" and "evil." Framing her violence as an effort at self-protection enabled Estela and the therapist to identify triggers to Estela's aggression, to place those triggers in a more realistic context, and to rehearse adaptive responses to them. For example, Estela reported during one session that her partner had called her a "bitch" when she refused to go out with him for the evening, and she responded by going to her room, practicing self-talking to calm herself, and listening to music on her favorite radio station. Before starting therapy, she said, she would have "hit him on the head with a frying pan." When the therapist asked her what the term bitch evoked for her, Estela reported that this was one of the epithets that her father habitually used against her mother during the numerous fights between them.

Alternating with her violent tendencies, Estela withdrew into profound periods of
Perinatal CPP employs a range of therapeutic modalities to promote mother-infant relationships.

depression during which she felt alone and worthless. The therapist asked her to create in her mind images of how she would have liked to be cared for, and these scenes evoked intense feelings of sadness intertwined with emerging compassion for her own mother and grandmother for the abuse and deprivation that they had also suffered. The therapist guided Estela in imagining different scenes of caregiving for the child she was carrying, asking her to anticipate specific daily routines and how she would like to respond to her baby’s needs. At first Estela felt awkward in engaging in this exercise, but in one important session she remembered a scene of her mother responding lovingly to her when she was sick by feeding her spoonfuls of hot chocolate, caressing her fevered forehead, and singing softly to her as she fell asleep. She retrieved from this remembered scene a feeling of complete peace and well-being. The clinician welcomed the emergence of this memory as an indication that Estela was able to retrieve and reexperience not only traumatic memories but also benevolent experiences from her past, “angels in the nursery,” that could serve as guides to loving childrearing. This memory gave way to others, expanding Estela’s sense of herself from someone who was completely unloved as a child to someone who was loved by parents who were themselves deeply damaged by their own experiences of violence and abuse.

Body-Based Interventions

The vaginal bleeding and early contractions reported by Estela were a clear indication that treatment needed to include attention to her body. The clinician consistently asked Estela to locate and describe bodily sensations as she recounted emotional experiences. During one session, Estela began talking about her dissatisfaction with her current situation with her partner, including his lack of financial support now that they were about to become parents. Her facial expressions alternated between worry and distress. The clinician stated, “I see how upset you feel as you talk about how dissatisfied you are about your current relationship with your partner.” Estela nodded in agreement and said, “Yes, I am frustrated and disappointed in him . . . but that’s the story of my life.” The therapist responded, “Tell me more . . . it sounds like you’ve experienced these feelings in the past.” Estela nodded and went on to say, “I always had to take care of myself. My mother couldn’t even take care of herself so I had to learn not to depend on anyone. So I should be used to this, I guess . . . I was always the responsible one.” Estela then went on to describe how her mother beat her up when she was 9 years old because she had forgotten to feed her 3-year-old sister who had been left under her care. As Estela spoke, the clinician pointed out the connections between what she was remembering and shifts in her affect from disappointment to hopelessness and then to rage and fear. She then asked Estela what her body was experiencing. Estela remained quiet for some time and said, “I am having trouble breathing and my heart is beating really hard.” The therapist then asked Estela how she would have liked her mother to respond when Estela forgot to feed her sibling. She answered, “I wish she had apologized and told me that it wasn’t my job to feed my sister, that I was only a little girl and should not have that responsibility.” The clinician asked how Estela’s body felt when she imagined her mother saying this. After a short silence, Estela replied, “It’s as if someone is soothing me inside.” This sequence was one of many other episodes where Estela learned that she could bring herself out of painful emotional states by imagining situations that made her feel safe and loved.

The clinician also monitored Estela’s body language and reactions as she spoke about traumatic events, making comments such as, “I notice you began rubbing your neck as you were talking about the beating. Does your neck hurt?” and “Your shoulders are raised, are you feeling tense?” Sometimes the clinician simply said, during a silence, “How are you feeling?” Following these discussions, the clinician provided psychoeducation about the impact of traumatic events on the body, saying, “Your body remembers. Your body reacts when you were speaking about the beating. It is communicating to you how it is also affected when you remember these painful experiences.” To alleviate the tension in Estela’s body, the clinician sometimes used breathing exercises and asked her to engage in slow movements to bring self-awareness of the body and the different sensations she was experiencing. Estela became increasingly more confident about gaining control over her emotions by turning her attention to her body.

Creating Images of the “Good Mother” for New Body-Based Memories

The theme of being “a good mother” became increasingly prominent as Estela prepared for the birth of her child. The clinician used Estela’s preoccupation with this theme to discuss the specifics of how Estela would want to respond to her baby’s distress, hunger, and need for physical care and emotional responsiveness. This allowed Estela to describe the type of mother she hoped to become—that is, loving, available, present, and accepting. As she imagined specific encounters with her baby where she responded in gentle and loving ways, Estela’s face and body became noticeably relaxed and she seemed happy and self-confident.
Estela’s labor and delivery proceeded smoothly, and her daughter was born at term with appropriate weight, height, and head circumference measures. Estela was able from the beginning to engage in sensitive caregiving to her child, and expressed great relief that she was not destined to become the kind of mother her own mother had been. During the 8 months of treatment that followed her daughter’s birth, Estela continued to make strides in gaining control over her outbursts of aggression. The traumatic memories of her childhood receded noticeably. She commented that she still had the memories but was no longer overcome by the emotions associated with them. She now felt primarily sad rather than angry when remembering her childhood. Her baby’s crying evoked in Estela a wish to respond in helpful ways: In mothering her baby, she was also mothering herself. At the end of treatment, Estela’s score for posttraumatic stress disorder was in the nonclinical range and her depression score has declined significantly. The baby’s cognitive and motor development was on target for her age, and she demonstrated the key hallmarks of an emerging secure attachment and healthy social–emotional functioning.

**Involving the Fathers**

Estela’s treatment outcome illustrates the opportunity for internal change in traumatized mothers as they prepare for their baby’s birth. This brings us to the obvious question: When and how to involve the fathers in treatment? The first consideration is whether the mother wants her partner to be involved. Many mothers in violent relationships use treatment as a private opportunity to safely explore whether they want to remain in the relationship and how they want the relationship to change now that there is a baby at stake. It is important to honor the mother’s motivations and enable her to use the treatment as a tool to plan for a safer future for herself and her baby. The second consideration is safety for the mother, the baby, and the clinician if treatment is offered. Many of the fathers are described by the mothers as unpredictably violent; others stalk the mothers after the relationship ends. There are sometimes court orders restricting the father’s access to the mother, child, or both. Each one of these situations needs careful evaluation in the decision to extend fathers an invitation to treatment.

We address the problem of safety by assessing the father’s capacity for self-reflection and remorse, potential for violence and lethality, and commitment to parenting prior to offering treatment. We adopted five criteria for offering treatment to a violent father: (a) the mother wants to include the father in the treatment; (b) the father acknowledges that he engages in violent behavior; (c) he expresses the wish to change and makes a commitment to refrain from violence during the treatment; (d) he is willing to participate in an anger management program in tandem with starting treatment; and (e) he signs releases of information that enable the clinician to gain access to information about him from all relevant sources, including mental health providers, probation officers, child welfare workers, and the courts.

In the case of Estela and her baby, containing the mother’s propensity for violence was the most immediate clinical priority. Estela herself stated that her partner had less difficulty than she did in curtailing his aggression, and throughout treatment she reported that he continued to make good use of his anger management program. These circumstances led to the choice to maintain a therapeutic focus on Estela’s clinical needs and on the mother–infant relationship as the focus of treatment.

**Treatment Effectiveness**

There is emerging evidence that perinatal CPP is effective in reducing maternal emotional problems and enhancing the mother–infant relationship. An open clinical trial comparing pre- and posttreatment scores of posttraumatic stress disorder and depression with a sample of 30 women revealed statistically significant symptom decline, with no overlap in the group scores between the two measurement periods. A measure of parenting attitudes and beliefs also revealed significant improvement following treatment with no score overlap between the pre- and posttreatment evaluations. None of the mothers showed neglect or engaged in abuse of their infants. All the babies performed at age level in the Mullen Scales of Development at the termination of treatment. Although the sample is small and the research design was not randomized, these promising findings warrant continued investment in clinical intervention for battered pregnant women and their babies.}

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**Learn More**

**NATIONAL CHILD TRAUMATIC STRESS NETWORK**

http://nctsn.org

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a collaboration of academic and community-based service providers. The project was developed to raise the standard of care and increase access to services for traumatized children and their families across the United States.

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

[www.women.gov/pregnancy](http://www.women.gov/pregnancy)

This federal government Web site provides information and resources to help women before, during, and after pregnancy.

**MIS PADRES, MIS MAESTROS: MY PARENTS, MY TEACHERS**

(bilingual Spanish/English parenting DVD; produced by El Valor)

[www.elvalor.org/programs/mispadres.html](http://www.elvalor.org/programs/mispadres.html)

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