Infant Mental Health

Progressive Case Conference

Facilitator's Guide

Contributors

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Session Structure

Sessions are typically designed to last 90 minutes. Prior to the session, trainees should read the articles included in the pre-reading section of this module. During the session, the cases will be distributed to trainees and will be read along by a resident volunteer. The entire group will then discuss the case as well as formulate the diagnosis and treatment approach based on facilitator guided questions. This session can be run by a single facilitator who oversees the entire group.

Goals and objectives

At the completion of this session, participants will be able to:

1. Name some of the parental and infant factors affecting parent-infant relationship
2. Understand some of the basic interventions in perinatal mental health clinical settings that can support parent-infant relationship

Resources Required

1. A faculty (or senior resident) facilitator
2. A white board, which can be helpful for writing notes during large group discussions
3. Facilitator and student guides

Pre-session Learning

Before you attend the classroom didactics on this module, please review some basic concepts regarding the parent-infant relationship by reviewing the following resources:

(1) Frosch CA, Schoppe-Sullivan SJ, O'Banion DD. Parenting and Child Development: A Relational Health Perspective. Am J Lifestyle Med. 2019 May 26;15(1):45-59. doi: 10.1177/1559827619849028. PMID: 33447170; PMCID: PMC7781063.

(2) https://parentinfantfoundation.org.uk/foundation-toolkit/chapter-2/

Session Outline

1. Review overview (10 minutes)
2. Case Study part 1 including reading of the case and discussion questions (20 minutes)
3. Case Study part 2 including reading of the case and discussion questions (20 minutes)
4. Case Study part 3 including reading of the case and discussion questions (20 minutes)

Overview

During the perinatal period, not only are women undergoing a significant developmental transition, their infant is developing rapidly within a relational context. An infant's early life experiences shape their brain development and lay the foundation for long term cognitive, behavioral, and health impacts (Clinton et al., 2016). The perinatal period offers an important opportunity for providers to evaluate and intervene within an infant mental health framework. Infant mental health refers to "the developing capacity of the child from birth to age three to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn–all in the context of family, community, and cultural expectations for young children." (Zero to Three Infant Mental Health Task Force Steering Committee, 2001). Infants develop within the context of their relationship with their primary caregivers, and the affective bond between caregiver and infant in the early postpartum period serves the foundation for the development of attachment.

Psychiatric conditions during the perinatal period can negatively impact bonding and attachment. When treating women during the perinatal period, it is important to consider how a woman is bonding with her infant and the ways in which she thinks and feels about her baby and her relationship with her baby. There are many factors that can impact the parent-infant relationship including a mother's own attachment relationships with her parents, having a history of trauma such as childhood trauma, domestic violence, or medical trauma for the mother or the infant, and the infant's temperament, behavior, and developmental needs. Addressing the parent-infant relationship while treating women during the perinatal period can lead to improvements in psychiatric symptoms for the mother while also promoting the infant's development. In this case conference, we show some of the ways in which the mental health clinician working with women during the perinatal period can assess parent-infant relational disturbances and help with more basic interventions.

Case study: Part 1

Ask one of the trainees to read the case out loud

Emilia is a 40 year old Chilean woman who is referred to you by her obstetrician at three weeks postpartum for evaluation and treatment of postpartum depression. Emilia presents to her evaluation session appearing tired and with a depressed affect. She tells you that she feels she does not know what she is doing and it seems everything is going wrong. She and her partner have very limited social support locally and she often feels alone. On further exploration, she reports she has had a very hard time breastfeeding, is constantly feeling overwhelmed, and feels the experience of becoming a mother has been very different from what she had imagined. Her pregnancy was very much desired, and she and her husband went through 3 rounds of IUI and 2 rounds of IVF. She tells you she has a hard time reading her son's cues and feels sure her son already knows that she is a failure as a mother. She and her partner have not been communicating well and have been getting into a lot of arguments. Over the course of the next few sessions you find out that when feeling depressed and rejected or inadequate, she withdraws and at times goes into the guest room in their loft and stays or sleeps there for hours. While withdrawing from her son and husband, she is acutely aware of the times that her son is calm or when her husband is playing with him. She interprets these as examples of her son not wanting her, and being happier with his father. You start her on an SSRI and titrate the

dosage, and eventually, to address residual symptoms, you add a second medication (Bupropion) for augmentation. You also see her weekly in psychotherapy and refer her to a postpartum support group to increase her support network. After a few months she responds very well to the medication regimen. During this period she continues struggling to feel competent or loved by her son, and during the more difficult periods she withdraws from him. She and her husband have grown further apart, and developed resentment and patterns of passive aggressive behavior toward each other.

Additional history for Emilia: her mother has struggled with chronic and untreated depression, and her father worked for very long hours and saw his main job as providing for his family. She has two other siblings to whom she does not feel connected. She is a professional and her career is a major part of her identity and way to differentiate herself from her mother. She has struggled with intermittent depressive episodes and chronic low to moderate levels of anxiety even prior to her pregnancy.

Case Questions/Discussion

Facilitator pauses for discussion

1. What are some risk factors for PPD for Emilia? *Elicit the following:*
    a. Past history of anxiety and depression
    b. Family history of depression
    c. Struggling with infertility prior to pregnancy
    d. Challenges with role transition from being a professional to a mother and a professional
    e. Limited social support, complex family relationships
    f. Minority status, separation from native country and culture

2. How is PPD affecting Emilia's bonding with her son? *Elicit the following:*
    a. She is having a hard time reading baby's cues
    b. She may be misinterpreting baby being (incidentally) calm with husband as her own failure
    c. She is having a hard time breastfeeding
    d. She feels sure her son already knows that she is a failure as a mother
    e. She is feeling rejected and therefore withdrawing from her son
    f. She is withdrawing from her husband. When under stress, they are using more passive aggressive styles of communication which worsens her emotional distress and leads to withdrawing more from both husband and baby

3. What role do you think Emilia's depression and life history is playing in her bonding with her baby? *Elicit the following:*
    a. Depression could lead to her misinterpreting interactions or being less responsive when interacting with her son
    b. Depression could lead to her becoming more easily dysregulated when her baby is in distress, which might in turn lead to her not being able to soothe/regulate her baby
    c. Her own attachment style with her parents might not have been secure or optimal, which can then influence her attachment style to those in her life, including her baby
    d. Depression and her previous experiences in relationships might impede a cohesive role transition in her family unit when her baby is born, which can have implications for each parent's relationship with the baby

e. Difficult emotions, and possibly traumatic events she might not have processed, can be retriggered. In the perinatal period, and while caring for a baby, her previous coping strategies to deal with these might not be enough

4. Given what we know about her parents, what further assessment and questions do you have about her own family, upbringing and history of attachments to loved ones? *Elicit the following:*
    a. How did Emilia perceive her parents' relationship with each other and their roles within the family unit?
    b. Did she feel closer to one parent over the other? What might be the reasons for her preferences?
    c. Did Emilia have a specific picture of what "an ideal mother" should be in her mind before her baby was born?
    d. How does Emilia think her experience of mothering is different in the U.S., as an immigrant, compared to her parents' experience in Chile?

5. How do you imagine her own history of attachment with her family of origin (parents, siblings) might affect her relationship with her son and husband and her experience of PPD? *Elicit the following:*
    a. Emilia built her identity primarily around her profession and when put in this new mothering role she struggles to feel competent
    b. Given her parents followed traditional gender roles, Emilia may feel an internal pressure to conform to the same role as her mother
    c. Given that her mother had chronic, untreated depression, it is possible that her mother was not emotionally available during Emilia's childhood. Her father specifically saw his role as providing for the family and thus unlikely to have sought a stronger emotional bond with Emilia. As such, she may not have had the advantage of secure attachment with either parent and thus could be struggling to find her own attachment with her baby.

Suggested reading:

Main M. (2021). Revisiting the founder of attachment theory: memories and informal reflections. *Attachment & human development*, *23*(4), 468–480. https://doi.org/10.1080/14616734.2021.1918447

Crockenberg, S. B. (1981). Infant Irritability, Mother Responsiveness, and Social Support Influences on the Security of Infant-Mother Attachment. *Child Development*, *52*(3), 857–865. https://doi.org/10.2307/1129087

Scharfe E. (2012). Maternal attachment representations and initiation and duration of breastfeeding. *Journal of human lactation : official journal of International Lactation Consultant Association*, *28*(2), 218–225. https://doi.org/10.1177/0890334411429111

Case study: Part 2

Ask one of the trainees to read the case out loud

Four years have passed. Emilia's mood and anxiety have been stabilized via continued individual therapy and on a regimen of sertraline 150mg and bupropion XL 300mg. In individual therapy, you have explored her feelings about her baby, herself as a mother, and her partner as a father. You have also explored her own dynamics with her parents during her childhood, as well as any intergenerational themes and the ways in which they have influenced her parenting. She has been able to discuss cultural factors impacting how she and her partner have adapted to their roles

as parents and difficulties navigating some more traditional division of roles. For the past year she has also been going to couples therapy and communication with her husband has significantly improved. During the course of the therapy you have explored the ways that she makes meaning of her son's behavior, particularly when she is feeling more depressed or at times when she feels less confident about her own ability to do what she imagines are the main maternal functions, such as soothing, feeding, and putting him to sleep. Through this work she has felt closer to her son and more confident about their bond and love, even when he is mad at her or prefers to spend time with his father.

Emilia is now pregnant again. This is another desired IVF pregnancy. She is very scared of re-experiencing severe postpartum depression, difficulty bonding, and conflicts with her husband this time around. After a detailed risk-risk analysis discussion, she has decided to continue her medication regimen without any changes during the perinatal period. You continue to meet with her on a regular basis for therapy and to closely monitor her mood and anxiety. Aside from her concerns about her postpartum period with this baby, she also feels very worried about how her son will cope with the shifts and transitions in the family.

She has a planned C/S for 37 weeks gestation. You see her two weeks postpartum and she continues to do well. She feels bonded to her daughter and continues to feel supported by her husband.

Case Questions/Discussion

Facilitator pauses for discussion

1. What are some of the factors that may impact how Emilia bonds with her daughter compared to her son? *Elicit the following:*
    a. Previous experience of PPD
    b. Differences in temperament between Emilia's son versus daughter (Goodness of fit) (1)
    c. Emilia and her husband are now more experienced parents
    d. Emilia and her husband have improved their communication and relationship through couples therapy (better family adjustment to the arrival of their second child)
    e. Emilia engaged in treatment prenatally
    f. Emilia maintained a stable mood continuing her medication regimen, therapy and with close monitoring
    g. Based on her earlier life experiences, Emilia is responding differently to having a daughter than she did to having a son.

2. What do you imagine the individual therapy work has consisted of to address her attachment issues with her son and better prepare her for her relationship with her daughter? *Elicit the following:*
    a. Allowed her to explore her expectations of motherhood, normalized how that might differ from reality and helped her define what kind of a mother she would like to be
    b. Helped her improve her understanding of the meaning of her child's behavior and reframe her children's behavior in a more balanced way
    c. Increased self-compassion and acceptance towards the wide range of feelings she may experience as a mother, even if at times those feelings are in contradiction (maternal ambivalence) (2)
    d. Discussion about how her experiences and anxieties about her relationship with her son might impact how she perceives her relationship with her daughter in the future. Similarly, this would be important to discuss during her pregnancy with her daughter and after she is born

3. How would you counsel Emilia on her worries about how this new transition will impact her family as well as how to help her son adjust to his new sibling? *Elicit the following:*
    a. Psychoeducation and reassurance that his is a common worry to have with any new transition in a family
    b. Emphasize "good enough" parenting (3)(4)
    c. Emphasize the importance of social support
    d. Help her work towards supporting and accepting the wide range of emotions her son might experience and express towards his sibling
    e. Work towards preparing her son prenatally about the transition, coming up with strategies about having special time with him postpartum, discussing parenting roles with her husband, etc
    f. Provide developmental guidance: such as emphasizing his role as a big brother and helper but also allowing her son to have moments of regression
    g. Reframing her son's adjustments to having a new sibling and the feelings and challenges that might come with that as an opportunity for him to learn and adapt

References and further readings:

(1) Seifer, R., Dickstein, S., Parade, S., Hayden, L. C., Magee, K. D., & Schiller, M. (2014). Mothers' appraisal of goodness of fit and children's social development. International Journal of Behavioral Development, 38(1), 86–97. https://doi.org/10.1177/0165025413507172
(2) Chapman, E., & Gubi, P. M. (2022). An Exploration of the Ways in Which Feelings of "Maternal Ambivalence" Affect Some Women. Illness, Crisis & Loss, 30(2), 92–106. https://doi.org/10.1177/1054137319870289
(3) https://www.seleni.org/advice-support/2018/3/14/the-gift-of-the-good-enough-mother
(4) Sutherland J. D. (1980). The British object relations theorists: Balint, Winnicott, Fairbairn, Guntrip. Journal of the American Psychoanalytic Association, 28(4), 829–860. https://doi.org/10.1177/000306518002800404

Case study: Part 3

Ask one of the trainees to read the case out loud

At 4 weeks postpartum Emilia starts telling you she has been having short periods of lower mood and feelings of extreme fatigue. You discuss sleep, going out for walks, improving communication with her husband about her needs, making sure she has playful times with her baby and has some one-on-one time with her son when possible. She has been struggling with milk production and even though she puts her baby on her breast regularly, at times for comfort nursing, she is starting to struggle with feelings of inadequacy and failure and tries to spend more time pumping to increase her milk production.

At 8 weeks postpartum she is reporting increased and longer periods of lower mood. Based on her history of responding better to an increase in the dose of Bupropion vs. Sertraline, you discuss increasing the dose of Bupropion, a strategy that had worked in the past. She is very hesitant due to worries about her baby's exposure through milk, and despite conversations with you and pediatrician about existing data, she decides against medication changes. Two weeks later she does not show up to her appointment, which is very unusual for her. You call her a couple of times and finally get hold of her that evening. She has been staying in her room alone the whole day, tells you she feels like "an absolute failure," her baby has been fussy and crying and she believes this is because she can't soothe her and is exposing her to medications in her milk. After getting a better history, it seems her baby has colic. You give her information about colic(5), ask her to get in touch with their pediatrician, and discuss the importance of working on decreasing depressive symptoms for her and her baby's sake. She tells you she is going to

think about it. She ends up going up on her Bupropion, reading more about colic, and reaching out to their pediatrician. A week later her mood is better. She is able to talk about her baby's "witching hour" in a different tone, and acknowledges that during those hours nobody and nothing seem to really calm her down.

Two weeks later, her mood is more euthymic, her sleep has improved and she tells you about how much fun she and her baby had the other day when she massaged (6) her with baby oil and took her to the bathtub to play. She laughs about how her baby's smiley face in the mornings make it possible to forget about her couple of hours of crying the night before.

Case Questions/Discussion

Facilitator pauses for discussion

1. How do Emilia's breastfeeding challenges, her baby's colic, and her depressive symptoms influence and exacerbate one another? *Elicit the following:*
    a. Emilia has been having trouble with milk production leading to feelings of inadequacy and failure, so she spends more time pumping to increase her supply. This is also bidirectional: stress and depression can lead to lower supply and difficulties with breastfeeding.
    b. Her baby's fussiness and crying exacerbate her feelings of failure and lead to withdrawal, thus increasing her depressive symptoms. Emilia's baby has colic, through no fault of her own. Research has shown that excessive fussiness and crying increases risk for postpartum depression. Having an infant with a medical illness or NICU hospitalization also increases the risk of developing anxiety, depression, and PTSD. (7)(8)

2. What might have been the impact of these factors (i.e., challenges breastfeeding, with colic, and postpartum depression) on Emilia's perceptions of her baby and their relationship? *Elicit the following:*
    a. These factors impacted the way that Emilia viewed her baby. Emilia viewed her baby as fussy and difficult to soothe. Emilia may perceive this as a characteristic of her baby's personality, even though colic is a temporary condition. These views could impact the way that Emilia perceives her baby and her personality in the future. The way in which parents make meaning of their infant's characteristics (e.g., being mellow, becoming distressed upon separation, etc) and of their medical or developmental conditions (e.g, being premature, having motor delays) can impact the way that they view and interact with their baby, potentially impacting the relationship and the child's sense of self.
    b. These factors also impacted the way that Emilia viewed herself. Emilia believed that she was unable to soothe her baby, feed her baby well, and that she was harming her baby through her medication. She also had a tendency to feel responsible and blame herself for her baby's fussiness. Overall these beliefs led her to perceive herself as not a good mother. When Emilia's mood improved, she was able to laugh and recognize that her baby had a "witching hour" and that the fussiness and crying was not her fault.
    c. These factors also impacted the way that Emilia viewed her relationship with her baby. The way in which Emilia viewed her baby and herself also can impact her perceptions about her relationship with her baby. It can also lead to changes in the way in which Emilia interacts with her baby. For example, Emilia may feel that her baby was rejecting her efforts at comforting her and therefore was rejecting her as a mother. This may then lead Emilia to disengage from interacting with her baby or become frustrated and make more efforts to control her baby.

3. How do you think that Emilia and her baby might influence one another's emotions and reactions? *Elicit the following:*
    a. The mother-baby dyad is in psychological and physiological communication with one another. Infants regulate through their caregiver and they are dependent on them to modulate their arousal and reactivity. This process is called co-regulation.
    b. Emilia's ability to be sensitive to her baby's cues and respond to her baby's emotions and needs are important for the development of secure attachment. It is important for parents to also be able to tolerate a wide range of affects and experiences that babies have.
    c. It is also important that Emilia learn how to reflect on her baby's emotions and the meaning of her baby's behavior (reflective functioning) and view their baby as their own individual with their own experiences. A parent's reflective functioning is also associated with the development of self-regulation and secure attachment for the baby. (*To learn more about attachment, review the self-study*)

4. What interventions did the therapist use and why might they have been helpful for Emilia? *Elicit the following:*
    a. The therapist provides psychoeducation about sleep, exercise, and taking breaks. The therapist also emphasizes the importance of improving communication with her husband about her needs, which is critical during the postpartum period. In addition, the therapist provides information about the social and emotional needs of infants and young children (developmental guidance (9)) by advising Emilia to have playful times with her baby and some one-on-one time with her son when possible
    b. The therapist provides medical information about colic, the benefits of increasing her medication, and addresses her concerns about her medication and breastfeeding
    c. Even though the therapist is working only with Emilia directly, she keeps Emilia's baby in mind throughout her work with Emilia. For example, the therapist considers what it might be like for the baby to be separated from Emilia while Emilia is isolated in another room during the crying spells, encourages playful time with the baby, and helps Emilia consider her view of her baby and their relationship. If there are concerns about the parent-infant relationship due to psychopathology, trauma, or concerns regarding attachment, it would be important to provide a referral for parent-infant psychotherapy which focuses on the relationship between the parent and the infant.

References and Further Reading:

(1) "The good enough mother begins in pregnancy" https://www.washingtonpost.com/news/parenting/wp/2017/01/04/the-good-enough-mother-begins-in-pregnancy/
(2) Meek, J., & Noble, L. (2022). Policy Statement: Breastfeeding and the Use of Human Milk. Pediatrics (Evanston), 150(1), 1.
(3) Ahluwalia, I., Morrow, B., & Hsia, J. (2005). Why Do Women Stop Breastfeeding? Findings From the Pregnancy Risk Assessment and Monitoring System. Pediatrics (Evanston), 116(6), 1408-1412.
(4) Shaw, R., Moreya, A., Dowtin, L. L., & Horwitz, S. M. (2020). Psychological adjustment in Mothers of Premature Infants. In R. J. Shaw & S. Horwitz (Eds.), Treatment of Psychological Distress in Parents of Premature Infants: PTSD in the NICU (pp. 67-92). American Psychiatric Association Publishing.
(5) https://publications.aap.org/patiented/article-abstract/doi/10.1542/ppe_schmitt_049/82277/Colic-Crying-Baby?redirectedFrom=fulltext

(6) Vicente, S., Veríssimo, M., & Diniz, E. (2017). Infant massage improves attitudes toward childbearing, maternal satisfaction and pleasure in parenting. *Infant behavior & development*, *49*, 114–119. https://doi.org/10.1016/j.infbeh.2017.08.006
(7) Ölmestig, T. K., Siersma, V., Birkmose, A. R., Kragstrup, J., & Ertmann, R. K. (2021). Infant crying problems related to maternal depressive and anxiety symptoms during pregnancy: a prospective cohort study. *BMC pregnancy and childbirth*, *21*(1), 777. https://doi.org/10.1186/s12884-021-04252-z
(8) Williams, A. B., Hendricks-Muñoz, K. D., Parlier-Ahmad, A. B., Griffin, S., Wallace, R., Perrin, P. B., Rybarczyk, B., & Ward, A. (2021). Posttraumatic stress in NICU mothers: modeling the roles of childhood trauma and infant health. *Journal of perinatology : official journal of the California Perinatal Association*, *41*(8), 2009–2018. https://doi.org/10.1038/s41372-021-01103-9
(9) https://www.aap.org/en/practice-management/bright-futures/bright-futures-family-centered-care/