Infant Mental Health

Progressive Case Conference

Trainee Guide

Contributors

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Structure of the session

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

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

1. What are some risk factors for PPD for Emilia?

2. How is PPD affecting Emilia's bonding with her son?

3. What role do you think Emilia's depression and life history is playing in her bonding with her baby?

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?

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?

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

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

1. What are some of the factors that may impact how Emilia bonds with her daughter compared to her 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?

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?

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

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

1. How do Emilia's breastfeeding challenges, her baby's colic, and her depressive symptoms influence and exacerbate one another?

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?

3. How do you think that Emilia and her baby might influence one another's emotions and reactions?

4. What interventions did the therapist use and why might they have been helpful for Emilia?

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/