Evidence-Based Treatment of Perinatal Trauma:

Cognitive Processing Therapy and Interdisciplinary Treatment Considerations

Kristen Lipari, PhD
Licensed Psychologist
President, Postpartum Health Alliance

National Perinatal Association Conference, Anaheim, CA
May 16, 2024

Learning Objectives

By the end of today's presentation, you will be able to:

- **Define** symptoms of perinatal trauma.
- **Identify** evidence-based treatment options for perinatal PTSD.
- **Explain** how perinatal PTSD can be addressed by Cognitive Processing Therapy (CPT).
- **Differentiate** between trauma-informed care and trauma-responsive care.
- **Describe** trauma-responsive interdisciplinary treatment considerations.

01

Perinatal Trauma: Symptoms & Semantics

Perinatal Trauma

Birth trauma includes births, whether preterm or full term, that are physically traumatic and "**births that are experienced as traumatic**, even when the delivery is obstetrically straightforward."

It is estimated that **4% of mothers meet full criteria for PTSD** and about **30% report trauma symptoms.**

Yildiz et al., 2017, Creedy et al., 2000.

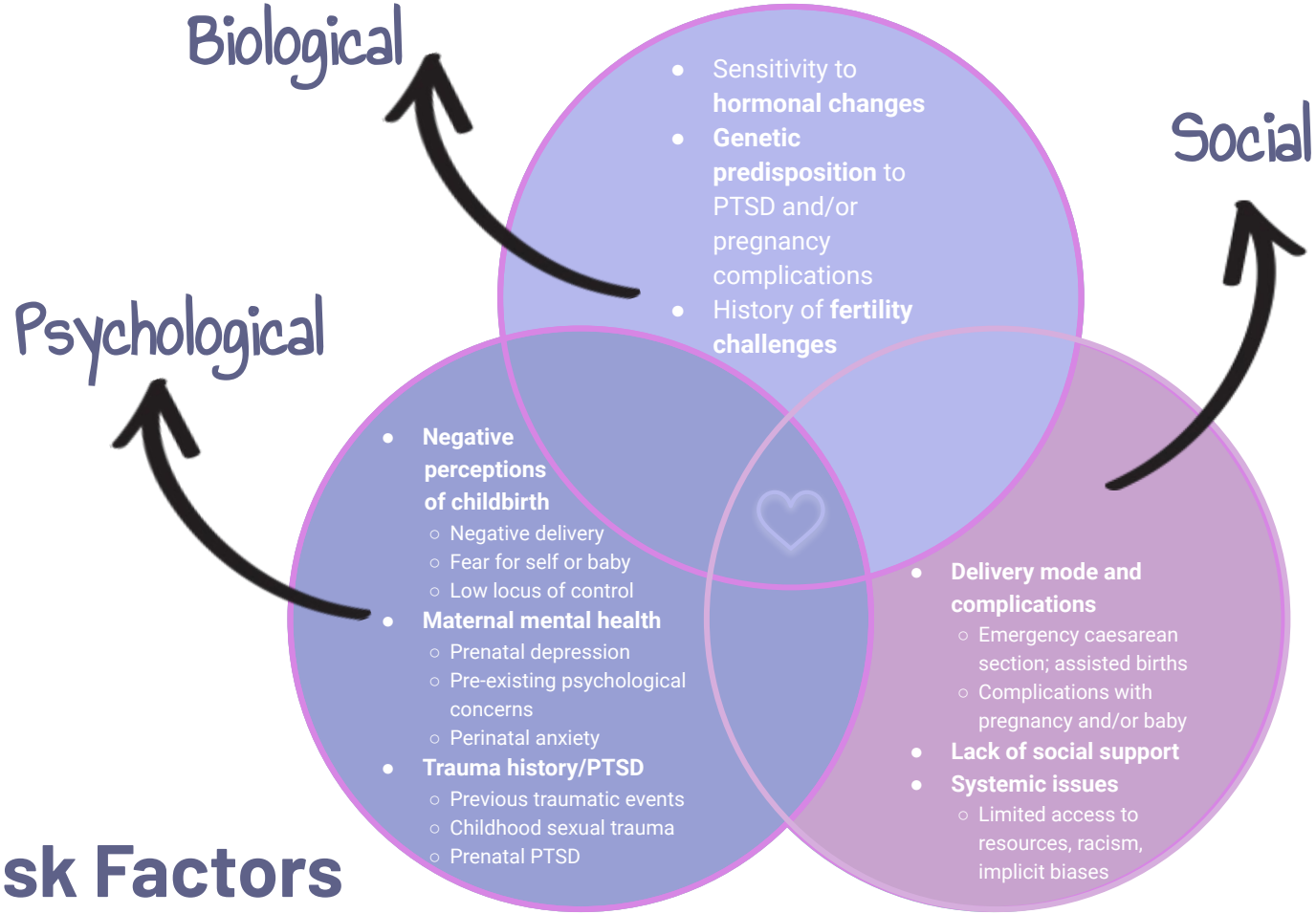
Perinatal Trauma

Perinatal trauma symptoms occur outside of birth trauma:

- **29%** of women met criteria for PTSD one month following **early pregnancy loss**
- **19%** continued to meet criteria after nine months

Farren et al., 2020.

Risk Factors



Dekel et al., 2017.

Provider Racism & Implicit Biases

Black women are **three times more likely to die** from a pregnancy-related cause compared to White women.

Racist stereotyping led practitioners to **ignore mothers' medical symptoms, requests for pain medication, and preferences** regarding medical interventions.

BIPOC mothers reported **feeling dismissed, dehumanized, invisible, and disrespected**. Mothers also reported long-term consequences of these experiences, including mental health impacts, mistrust of the medical community, and a decreased desire to have more children.

CDC, 2021; Dmowska et al., 2023.

Vulnerabilities in Pregnancy and Childbirth

Physical

undressed, exposed, vulnerable and intimate positions, invasive exams, not able to move (epidural), unable to eat

Psychological

dependency on others (strangers), loss of autonomy, feeling disempowered, lack of control, fight/flight response

Symptoms of Perinatal Trauma

Re-experiencing

Re-living the worst moments of childbirth or loss through dreams, flashbacks, intrusive images, or memories.

Avoidance

Avoidance of trauma reminders (e.g. interacting with baby, driving past the hospital, taking pregnancy tests, talking about birth, attending medical appointments) can compromise access to necessary care.

Negative Cognitions and Mood

Strong negative beliefs about self, others, the world (e.g. "I'm to blame for what happened," "Doctors can't be trusted"), no interest in previously enjoyable activities, feeling detached from others, disinterested in baby, irritability, lack of positive feelings.

Hyperarousal

Difficulty sleeping (when given the opportunity), difficulty concentrating on simple tasks, hypervigilance (checking to see if baby is breathing, preoccupied with self or baby getting hurt), exaggerated startle response.

Kerr et al., 2023; COPE, 2024.

02

Evidence-Based Treatments

APA Clinical Practice Guidelines for PTSD

Strongly-Recommended	Suggested Treatments	Insufficient Evidence
Cognitive Processing Therapy (CPT)	Brief Eclectic Psychotherapy (BEP)	Seeking Safety (SS)
Cognitive Behavioral Therapy (CBT)	Eye Movement Desensitization and Reprocessing (EMDR)	Relaxation (RLX)
Cognitive Therapy (CT)	Narrative Exposure Therapy (NET)	
Prolonged Exposure (PE)		

CPT for PTSD

Short-term (8-15 week) cognitive behavioral therapy for PTSD, in which the provider helps the client examine the **impact of a traumatic event** on their life and helps to **challenge and change unhelpful thoughts** related to the event, as well as beliefs about one's self, others, and the world.

Goal is to help client:

- Compassionately accept what happened
- Feel their emotions about it
- Develop balanced and realistic beliefs

03

Case Study: Cognitive Processing Therapy for Perinatal PTSD

Case Study

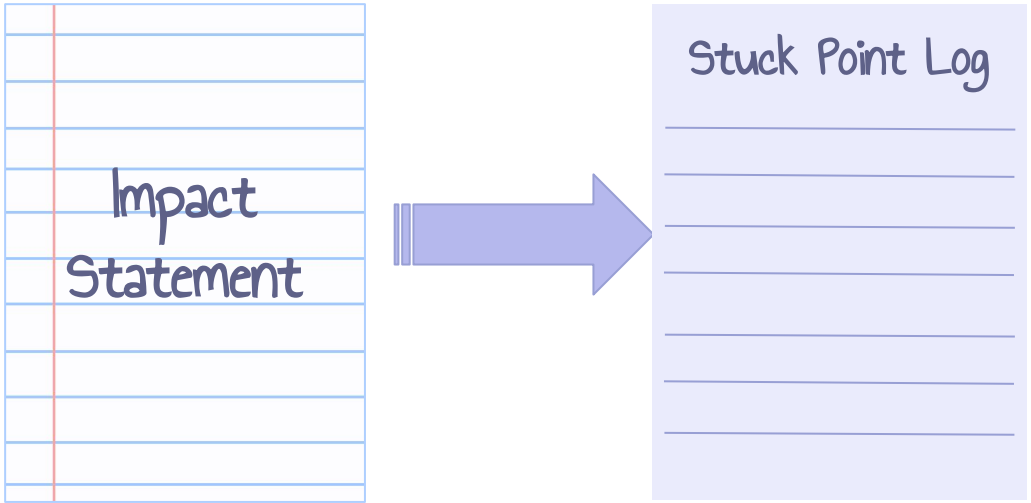
Jessica is a 38-year-old, married, straight-identified, Mexican-American, Catholic, married cisgender female (she/her/hers). She experienced a difficult labor and delivery of her first child who was born at 36 weeks and required a month-long NICU stay.

During her labor, her baby's heartbeat dropped to concerning levels and suddenly over a dozen providers were at their bedside. No one explained to Jessica what was happening. She overheard one provider talk about her "suboptimal" lunch, while she laid on her delivery bed, unable to move due to having an epidural and stunned into silence, unable to think or speak. She felt helpless and alone despite being in a room full of people.

Following childbirth, her son was not taking full breaths and was quickly evaluated by the NICU team, who expressed concern that he "may be septic" or "have a serious infection" that could compromise his well-being. The NICU pediatrician did not stay to answer Jessica's questions and Jessica's partner followed the baby to the NICU. Again, Jessica was too shocked to think and remained silent. In fact, 20 minutes after giving birth, she found herself alone in the room with one nurse who was kind enough to offer her a snack, but did not adequately address her emotional needs.

Psychoeducation & Impact Statement

Assignment: Write one page about why you think your birth trauma occurred. Write about the impact of this traumatic event on how you think about yourself, other people, and the world in terms of the following themes: safety, power/control, trust, intimacy, and esteem.



Resick, Monson, and Chard, 2023.

Sample Stuck Points

Safety
If I have another baby, there will be complications.
The doctors couldn't keep my baby safe.

Trust
I knew something was wrong and I didn't speak up; I can't trust my judgement.
I don't trust any providers to guide me; I'm just another patient to them.

Power/Control
I am completely powerless in labor/delivery.
Doctors have all of the power at the hospital; my needs don't matter.

Sample Stuck Points

Intimacy

I can't be there for myself; this was all too much for me.
My husband just left with our son; he didn't think about connecting with me and making sure I was taken care of.

Esteem

I am damaged; my body failed me in delivery. I'm not meant to have another baby.
I don't have the strength to speak up for myself, so I got what was coming to me.
I have no faith in the healthcare system; I'm just a number to them and they don't really care about me.

ABC Worksheet

ACTIVATING EVENT A "Something happens."	BELIEF/STUCK POINT B "I tell myself something."	CONSEQUENCE C "I feel something."
I was laying alone in my recovery room and reflecting on what happened.	I didn't have the strength to speak up for myself, so I got what was coming to me.	weak inadequate powerless

Are my thoughts above in "B" *realistic*?

No. I did try to alert the nurse when I saw the baby wasn't breathing.

What can you tell yourself on such occasions in the future?

I don't deserve to be alone, in pain, and scared. There wasn't anything I could have done to change this outcome. It's not fair to blame myself.

Challenging Questions & Thinking Patterns

Challenging Questions Worksheet

Below is a list of questions to be used in helping you challenge your maladaptive or problematic beliefs/stuck points. Not all questions will be appropriate for the belief/stuck point you choose to challenge. Answer as many questions as you can for the belief/stuck point you have chosen to challenge below.

Belief/Stuck Point:_____

1. What is the evidence for and against this stuck point?
   FOR:

   AGAINST:
2. Is your stuck point a habit or based on facts?
3. In what ways is your stuck point not including all of the information?
4. Does your stuck point include all-or-none terms?
5. Does the stuck point include words or phrases that are extreme or exaggerated (i.e., always, forever, never, need, should, must, can't, and every time)?
6. In what way is your stuck point focused on just one piece of the story?
7. Where did this stuck point come from? Is this a dependable source of information on this stuck point?
8. How is your stuck point confusing something that is possible with something that is likely?
9. In what ways is your stuck point based on feelings rather than facts?
10. In what ways is this stuck point focused on unrelated parts of the story?

Patterns of Problematic Thinking Worksheet

Listed below are several types of patterns of problematic thinking that people use in different life situations. These patterns often become automatic, habitual thoughts that cause us to engage in self-defeating behavior. Considering your own stuck points, find examples for each of these patterns. Write in the stuck point under the appropriate pattern and describe how it fits that pattern. Think about how that pattern affects you.

1. **Jumping to conclusions** or predicting the future?
2. **Exaggerating or minimizing** a situation (blowing things way out of proportion or shrinking their importance inappropriately).
3. **Ignoring important parts** of a situation.
4. **Oversimplifying** things as good/bad or right/wrong.
5. **Over-generalizing** from a single incident (a negative event is seen as a never-ending pattern).
6. **Mind reading** (you assume people are thinking negatively of you when there is no definite evidence for this).
7. **Emotional reasoning** (using your emotions as proof, e.g., "I feel fear so I must be in danger")

Challenging Beliefs Worksheet

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use **Challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
I was laying alone in my recovery room and reflecting on what happened.	I didn't have the strength to speak up for myself, so I got what was coming to me. (90)	Evidence For? I was silent when I wish I would have asked questions. Evidence Against? Even if I spoke up, that may not have helped the situation. Habit or fact? Habit; this is something I tell myself a lot. Not including all information? I did try to tell the nurse when I saw the baby wasn't breathing. All or none? Extreme or exaggerated? It's extreme to say I deserved to struggle. Focused on just one piece? Focused on crisis; I did speak up when baby was in NICU. Source dependable? No. I'm looking for a reason this happened, blaming myself. Confusing possible with likely? It's possible my silence changed the course of treatment, but not likely. Based on feelings or facts? Feelings are leading this thought. Focused on unrelated parts? Yes, focused on whether I spoke up which isn't relevant to what happened.	Jumping to conclusions: Yes, assuming if I spoke up the outcome would have changed. Don't know this. Exaggerating or minimizing: Exaggerated to say I deserved to struggle. Ignoring important parts: Ignores all of the times I did speak up for him. Oversimplifying: False assumption that speaking up would have changed something. Was much more complicated than that. Over-generalizing: Mind reading: Emotional reasoning: Because I feel inadequate, I must have done something wrong.	I was shocked at what was happening and unable to advocate for myself or the baby because that's what happens in fight/flight. No one deserves to feel powerless like I did and I'm not to blame for him needing to go to the NICU. (70)
	C. Emotion(s) Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% weak (100) inadequate (90) powerless (100)			**G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% 20 **H. Emotion(s)** Now what do you feel? 0-100% weak (30) inadequate (10) powerless (40)

Creating Balanced Thoughts

Creating Balanced Thoughts

Safety

If I have another baby, there will be complications.

I might feel anxious about another pregnancy, but having one complicated L/D doesn't mean that will happen again.

The doctors couldn't keep my baby safe.

The NICU doctors did actually keep him safe. I was just scared of what that one pediatrician said to me.

Trust

I don't trust any providers to guide me; I'm just another patient to them.

Some providers were not especially kind, but ultimately their medical advice was sound.

Power/Control

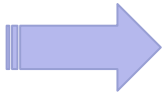
I am completely powerless in labor and delivery.

It's understandable that I may not be able to speak up in crisis, but that doesn't mean I am powerless. My partner and most of my nurses advocated for me.

Creating Balanced Thoughts

Intimacy

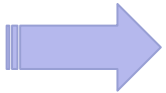
My husband just left with our son; he didn't think about connecting with me and making sure I was cared for.



I encouraged my husband to go down to the NICU with our son. This must have been a hard choice because he hesitated, but ultimately our son needed his warmth and care, even if I too was scared and needed to feel cared for.

Esteem

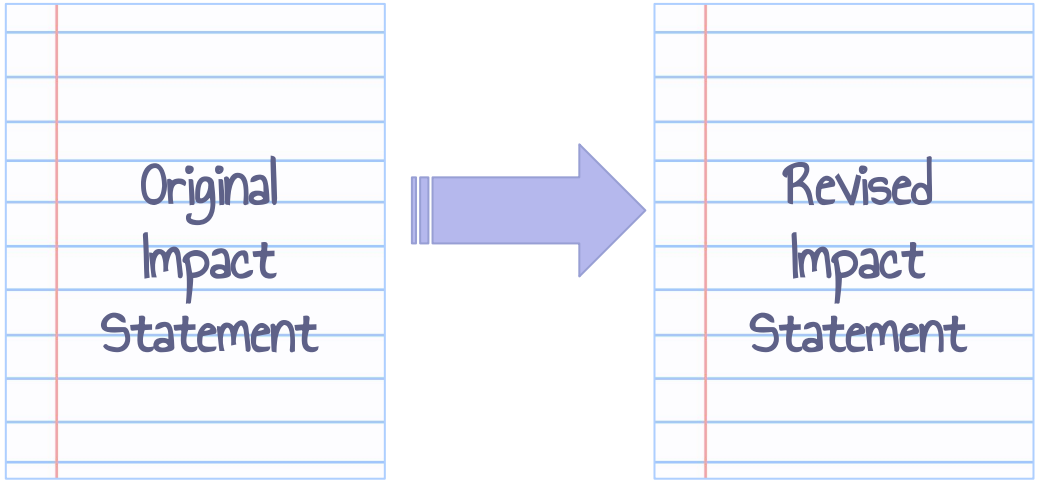
I am damaged; my body failed me in delivery. I'm not meant to have another baby.



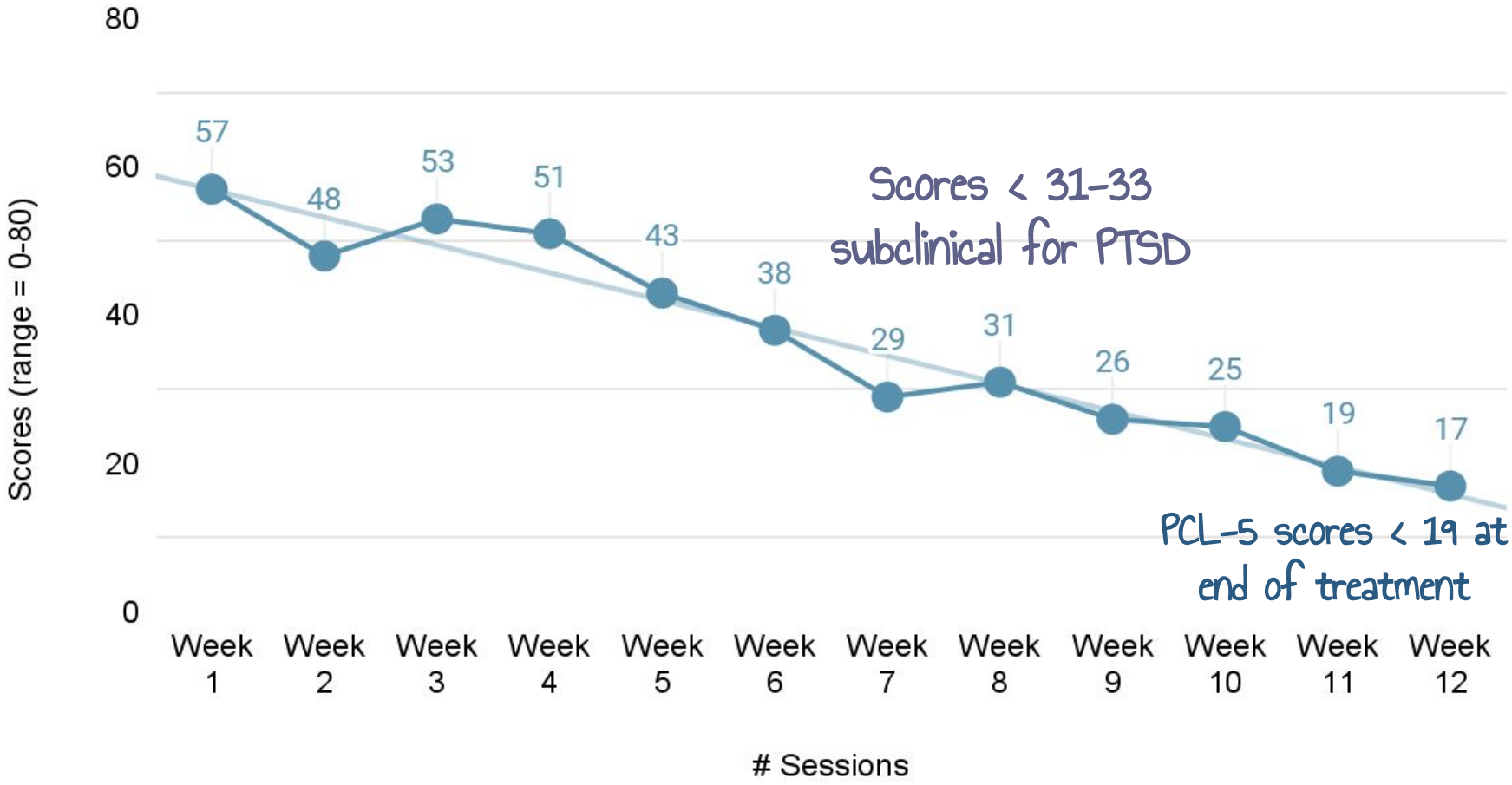
My body is strong and delivered a baby who is ultimately thriving.

Revised Impact Statement

*Assignment: Please write at least one page about how you **now** think about why this traumatic event occurred. Consider what you believe now about yourself, others, and the world in the following areas: safety, trust, power/control, esteem, and intimacy.*



PCL-5 Weekly Scores



04

Interdisciplinary Treatment Considerations: Trauma-Responsive Care

“Trauma is not what happens to us, but what we hold inside in the absence of an empathic witness.”

Peter Levine

Trauma-Informed

Recognizes the possibility of treating someone with existing traumatic experiences. Keeps this possibility in mind, but prioritizes medical intervention without treating patients like unique individuals.

Trauma-Responsive

Assumes presence of trauma risk factors and delivers care to prevent further traumatization. Proactively addresses unavoidable traumatic events in perinatal care.

The Case for Trauma-Responsive Care

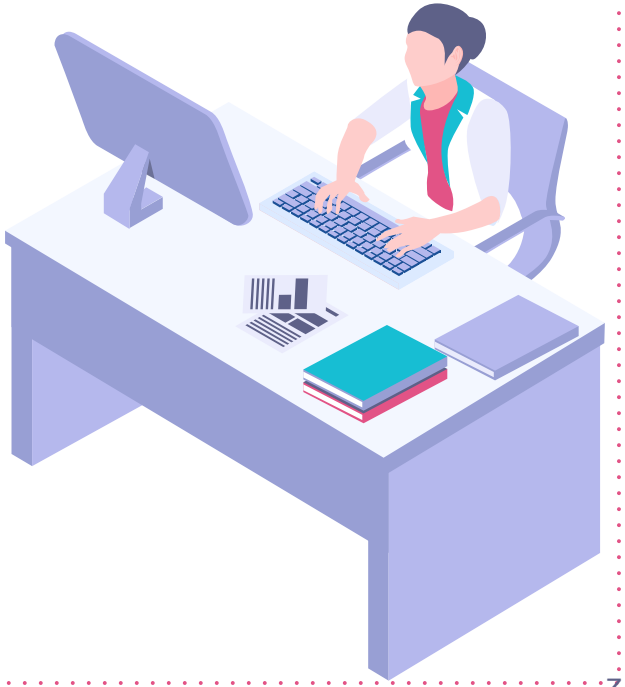
Perceived lack of support throughout child birth and **negative interpretations of health care staffs' behavior** predict PTSD (Kerr, et al., 2023).

Negative subjective experience of childbirth emerged as the most important predictor of postpartum PTSD. (Dekel et al., 2017).

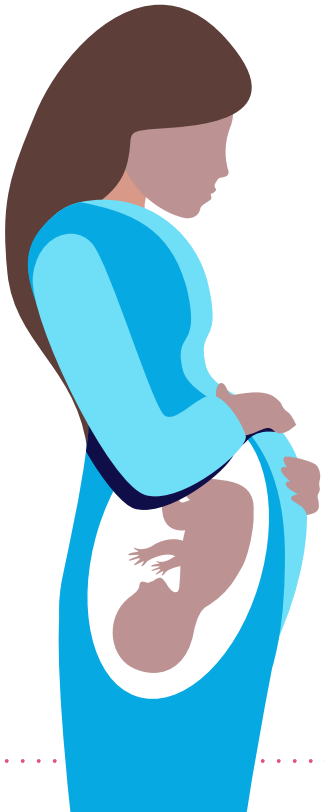
Evidence that (clinician and midwife-led) **early psychological interventions** administered **within 72 hours of a traumatic birth reduces symptoms of PTSD** at 4 to 6 *and* 12 weeks postpartum vs. care as usual (Taylor, et al., 2021).

Barriers to Trauma-Responsive Care

- **Impacted healthcare system**; shortage of nurses, physicians, and staff.
- Insurance and corporate hospital systems encourage **maximum earnings and limited duration and frequency of visits**.
- Providers' **lack of confidence** discussing mental health concerns, **inconsistent screening** practices, discontinuity of care, **stigma**, and limited **access to care** (Viveiros and Darling, 2019).



Prevention of PTSD for BIPOC Patients



Doula care has been shown to improve rates of cesarean section, preterm birth, infant mortality, maternal stress, and mothers' self-efficacy during labor.

Patient-physician racial concordance increases patients' trust, satisfaction, use of services, and involvement in decision-making and decreases feelings of being misunderstood, unsafe, and uncared for.

Educating healthcare professionals about systemic racism, implicit biases, and cultural competence prevents racism and reduces traumatic birth and maternal mortality.

Dmowska, et al., 2023.

Interdisciplinary Treatment Considerations

01

Maximize Agency

Provide informed consent

- ➔ Inform patient on the risks/benefits of treatment options
- ➔ Ask permission before preceding
  - ◆ *"Is it ok if I begin?"*
- ➔ Check in; allow patient to change their mind when possible
  - ◆ *"How are you doing," "Is it ok to proceed?"*

Encourage patient-led decision making

- ➔ Empower choices about pain management, feeding baby, type of therapy
- ➔ Respect their choices
  - ◆ Let them own their birth and recovery experience
  - ◆ Do not use leading language, question choices, or jump to conclusions about their preferences (your values are not their values)
- ➔ Collaborate (when asked) on a care plan that maximizes safety

Interdisciplinary Treatment Considerations

02

Educate the Patient

Inform patients about what they can expect

- ➔ *"CPT typically lasts 12 sessions. Here's handout of what to expect each week."*
- ➔ *"After an epidural some people experience XYZ."*
- ➔ *"After the delivery you may experience shaking or continued contractions."*

Narrate what is happening to help patient form a cohesive, linear narrative

- ➔ *"First I am inserting the misoprostol. You may feel a little pressure."*
- ➔ Explain who is in the room, their specific roles

Screen for perinatal mental health disorders

- ➔ Screen patient privately
- ➔ Educate support person to recognize signs of distress
- ➔ Provide resources

Empower patients to ask questions

- ➔ *"What else are you curious about?"*
- ➔ *"What else is on your mind?"*

Interdisciplinary Treatment Considerations

03

Convey Care

Be an empathic witness

- ➔ Attune to big feelings; respond with empathy
- ➔ Normalize pain and struggles, e.g. *"We all manage pain differently."*
- ➔ Take the time to address questions

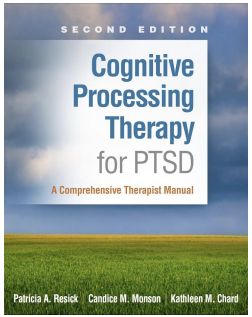
Use caring body language, speech, and tone

- ➔ Consider sitting next to them vs. across from them
- ➔ Turn toward the patient, maintain eye contact when possible
- ➔ Convey confidence; be calm and clear
- ➔ Speak respectfully and use encouraging language
  - ◆ *"When you are ready..."*
  - ◆ *"You are doing great"*

Recognize if you've gone off course

- ➔ *"This is not what you were expecting or hoping for, but baby will be here soon, we're just taking a different path."*

Resources



CPT Treatment Manual,
(Resick et al., 2023)

Workshops/Trainings, Resources, Videos
cptforptsd.com

USU | CDP
Uniformed Services University | Center for Deployment Psychology

2-Day Workshop & Consultation

MUSC
Medical University of South Carolina

Online Training/ Refresher Course

COGNITIVE BEHAVIOR INSTITUTE

2-Day Virtual Intensive

Questions?

Thank You

Kristen Lipari, PhD
Licensed Psychologist in Private Practice
President, Postpartum Health Alliance

doctorlipari@gmail.com
@doctorlipari
doctorlipari.com
postpartumhealthalliance.org

References

American Psychological Association. (2017). Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults. https://www.apa.org/ptsd-guideline

Centre of Perinatal Excellence. (2024). Post-traumatic stress disorder (PTSD) after birth. https://www.cope.org.au/preparing-for-birth/things-dont-go-plan/post-traumatic-stress-disorder-ptsd-2/

Creedy, D. K., Shochet, I. M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: incidence and contributing factors. *Birth Issues In Perinatal Care*, 27, 104–111.

Dekel, S., Stuebe, C., & Dishy, G. (2017). Childbirth induced posttraumatic stress syndrome: a systematic review of prevalence and risk factors. *Frontiers in Psychology*, 8, 560.

Dmowska, A., Fielding-Singh, P., Halpern, J. H., & Prata, N. (2023). The intersection of traumatic childbirth and obstetric racism: A qualitative study. *Birth Issues In Perinatal Care*. https://doi.org/10.1111/birt.12774

Hoyert, D. L. (2021). Maternal mortality rates in the United States. *Center for Disease Control.* https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf

References

Farren, J., Jalmbrant, M., Falconieri, N., Mictchell-Jones, N., Bobdiwala, S., Al-Memar, M., Tapp, S., Van Calster, B., Wynants, L., Timmerman, D., & Bourne, T. (2020). Posttraumatic stress, anxiety and depression following miscarriage and ectopic pregnancy. *American Journal of Obstetrics and Gynaecology*, 222, 367.

Resick, P.A., Monson, C. M. & Chard, K. M. (2017). *Cognitive Processing Therapy for PTSD: A comprehensive manual*. Guilford Press.

Taylor, P.G., Sinclair, P., McCullough, E. M., Miller, D. P., Slater, P. F., Shapiro, E., & Klaus, P. (2021). Early psychological interventions for prevention and treatment of post-traumatic stress disorder (PTSD) and post-traumatic stress symptoms in post-partum women: A systematic review and meta-analysis. Public Library of Science. https://doi.org/10.1371/journal.pone.0258170

Viveiros, C. J., & Darling, E. K. (2019). Perceptions of barriers to accessing perinatal mental health care in midwifery: A scoping review. *Midwifery*, 70:106-118.

Yildiz, P. D., Ayers, S., & Phillips, L. (2017). The prevalence of posttraumatic stress disorder in pregnancy and after birth: a systematic review and meta-analysis. *Journal of Affective Disorders*, 15, 634–645