The Redleaf Way: Integrating Reproductive Psychiatry, Infant and Early Childhood Mental Health, and Reproductive Justice

Helen Kim, MD
Jesse Flynn, LICSW, IMH-E
Redleaf Center for Family Healing
Hennepin County Medical Center
Hennepin Healthcare System
Minneapolis, Minnesota

Redleaf Center
For Family Healing

Agenda

- **8:25-9:30am** Introduction to The Redleaf Way
- **9:30-10:00am** Building Awareness through a Cultural Autobiography – *Individual and Small Group Activity*

Break 10:00am-10:15am

- **10:15-11:15am** Overview of Reproductive Psychiatry
- **11:15-12:15pm** Overview of Infant and Early Childhood Mental Health

Lunch 12:15pm-1:15pm

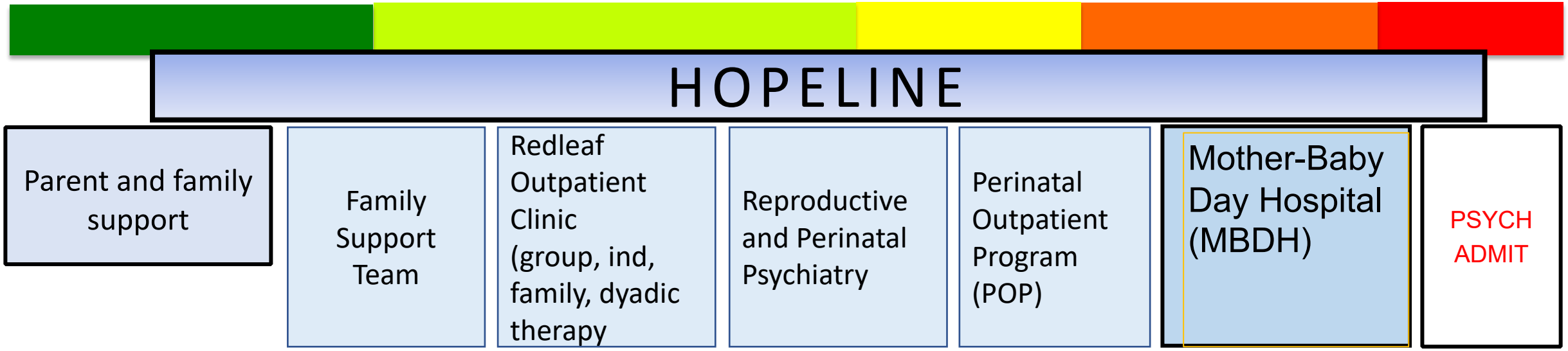
- **1:15-2:00pm** Mother-Baby Program Group Experience – *Mindful Movement and Discussion*
- **2:00-2:45pm** Introduction to the Mother-Baby Clinical Model

Break 2:45pm-3:00pm

- **3:00-3:45pm** Clinical Application: Case Formulation – *Small Group Activity*
- **3:45- 4:00pm** Q and A

Redleaf Center
For Family Healing

Mental healthcare for families expecting a baby or parenting children 0-5



HennepinHealthcare

The Redleaf Way

Objectives

1

Context of the perinatal period in the U.S.

2

Reproductive Justice as unifying human rights frame and a stage of healing

3

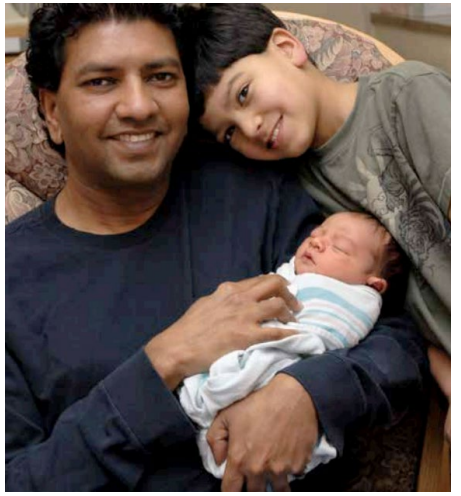
The Redleaf Way

Redleaf Center
For Family Healing

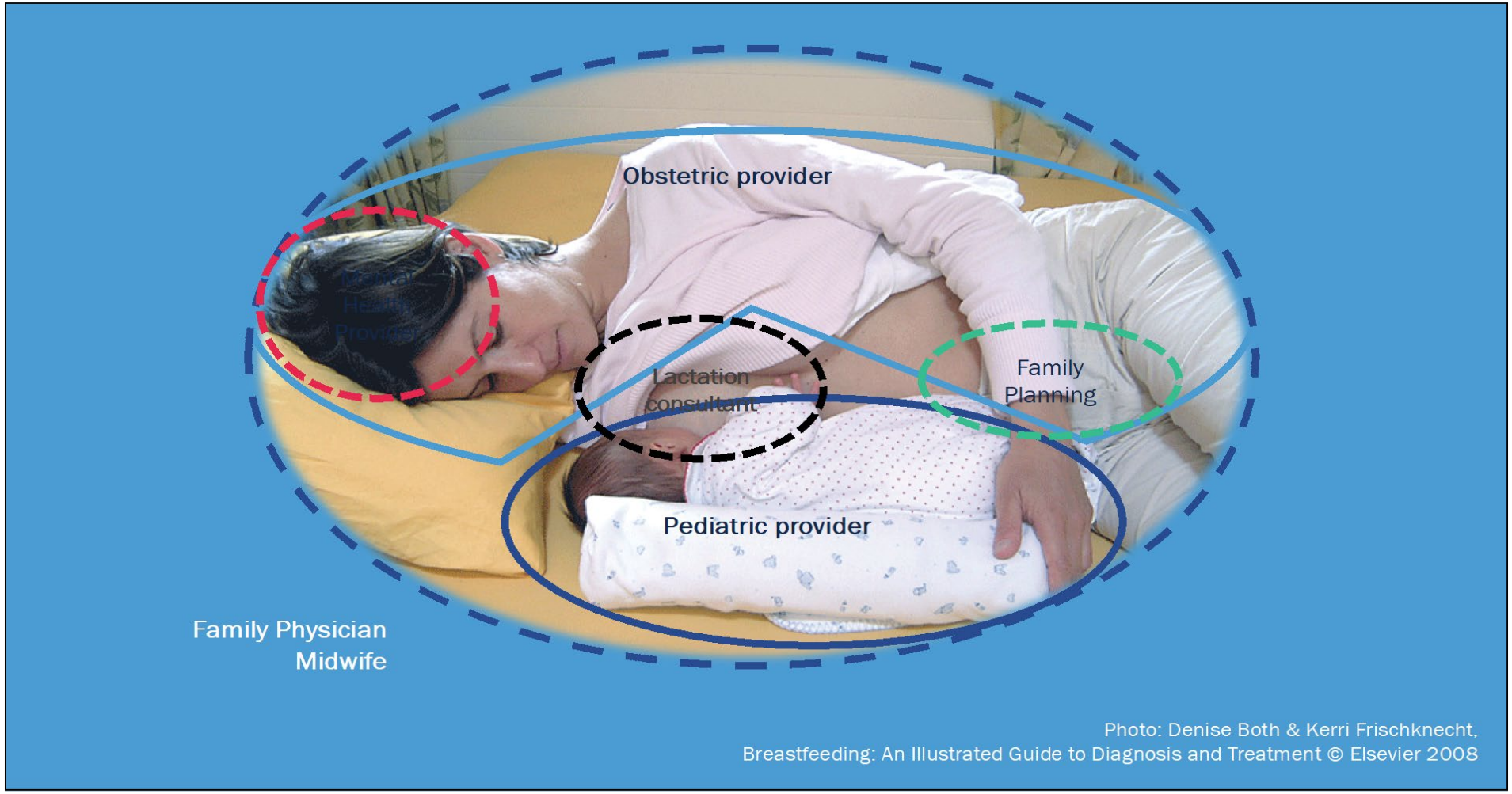
Objective One

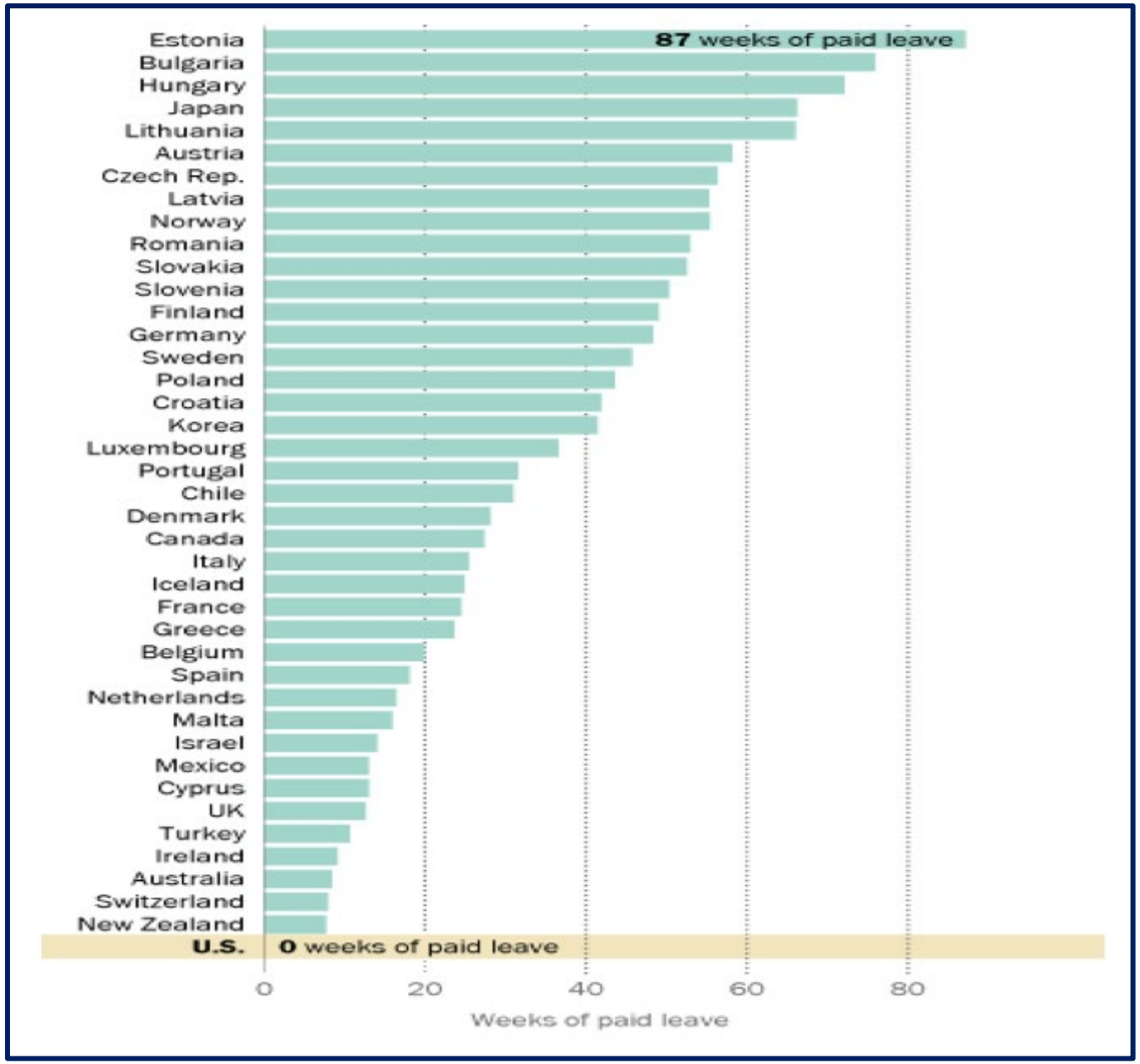
Context of the perinatal period in the U.S.

Perinatal Families in the U.S. are beautifully diverse



Healthcare System view of the Perinatal Period

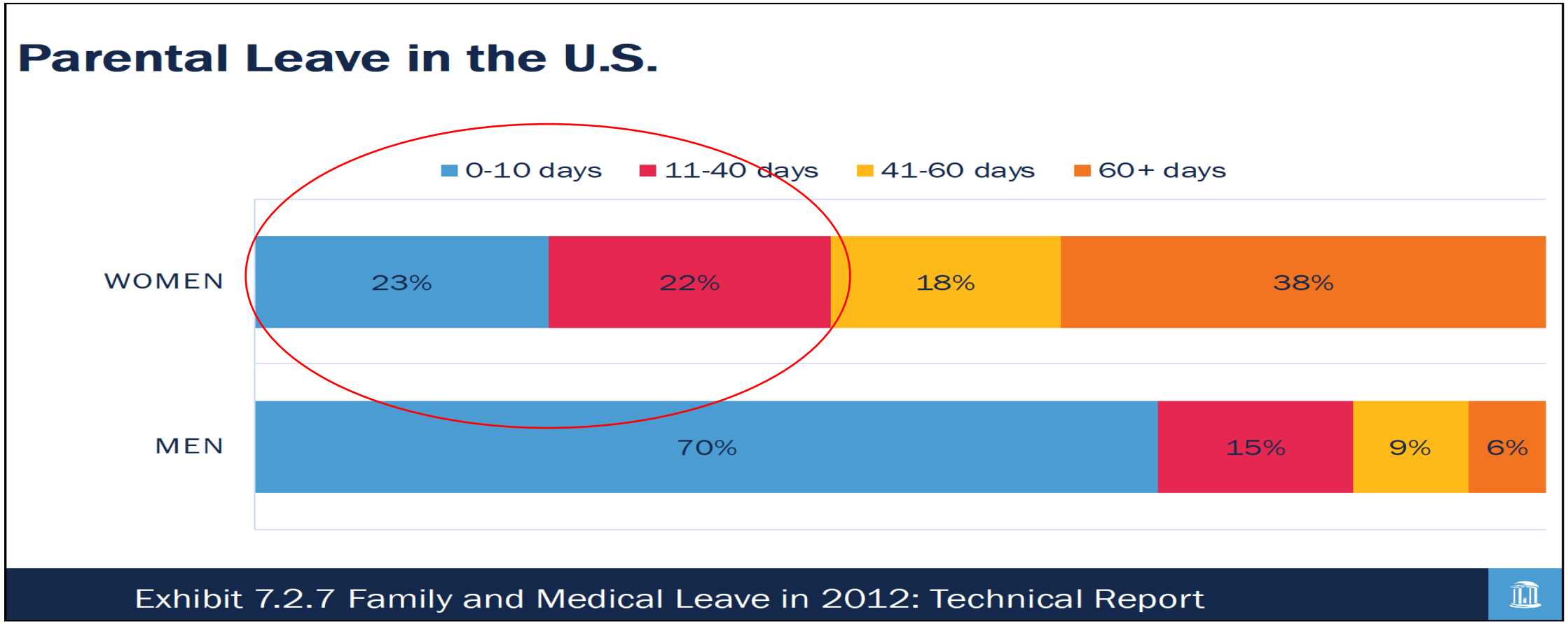




U.S. is the only developed country with **NO** paid parental leave

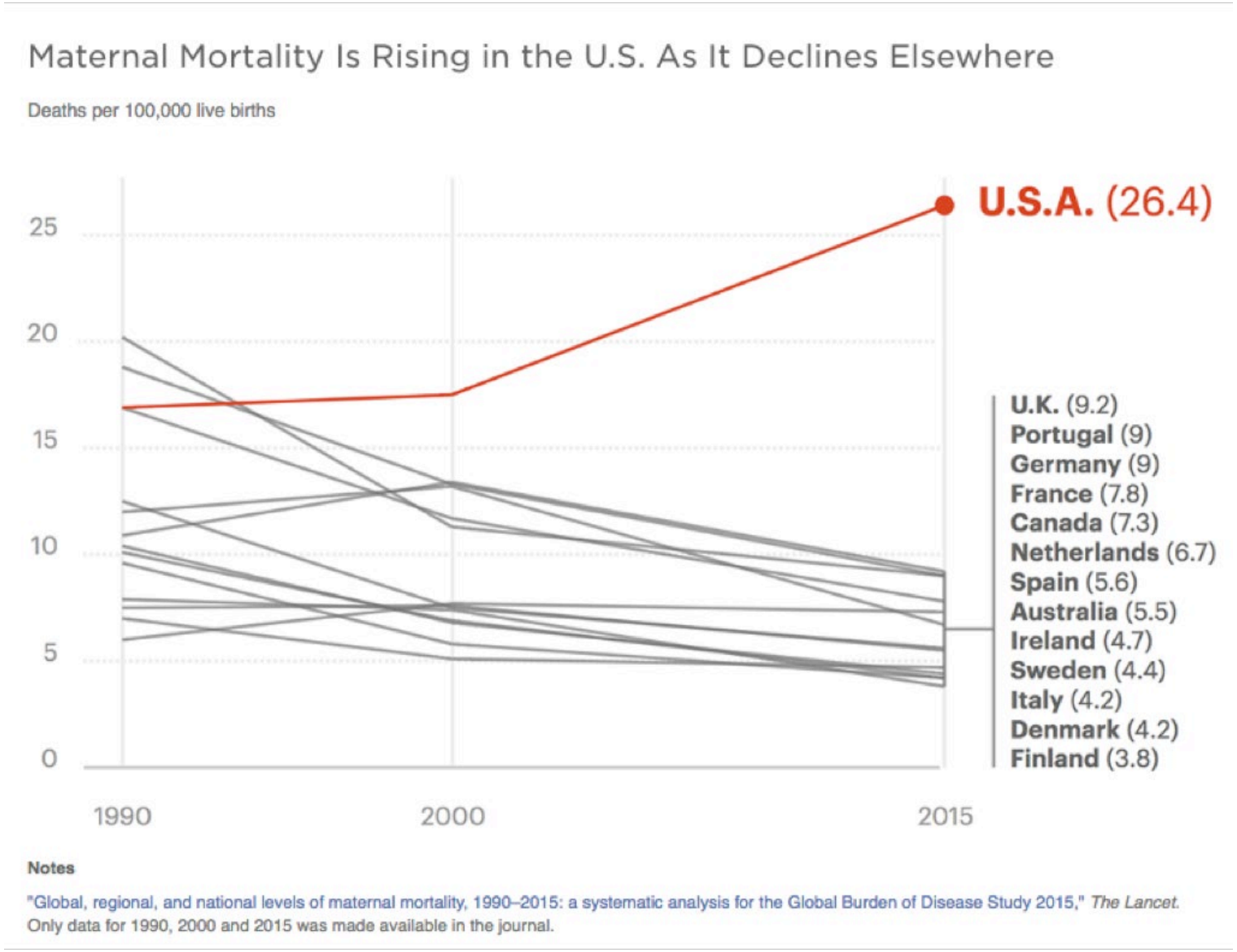
Organization for Economic Cooperation and Development (OECD), Aug 2019

- 1/4 mothers are back at work within 10 days after delivery
- Nearly 1/2 back at work within 40 days after delivery

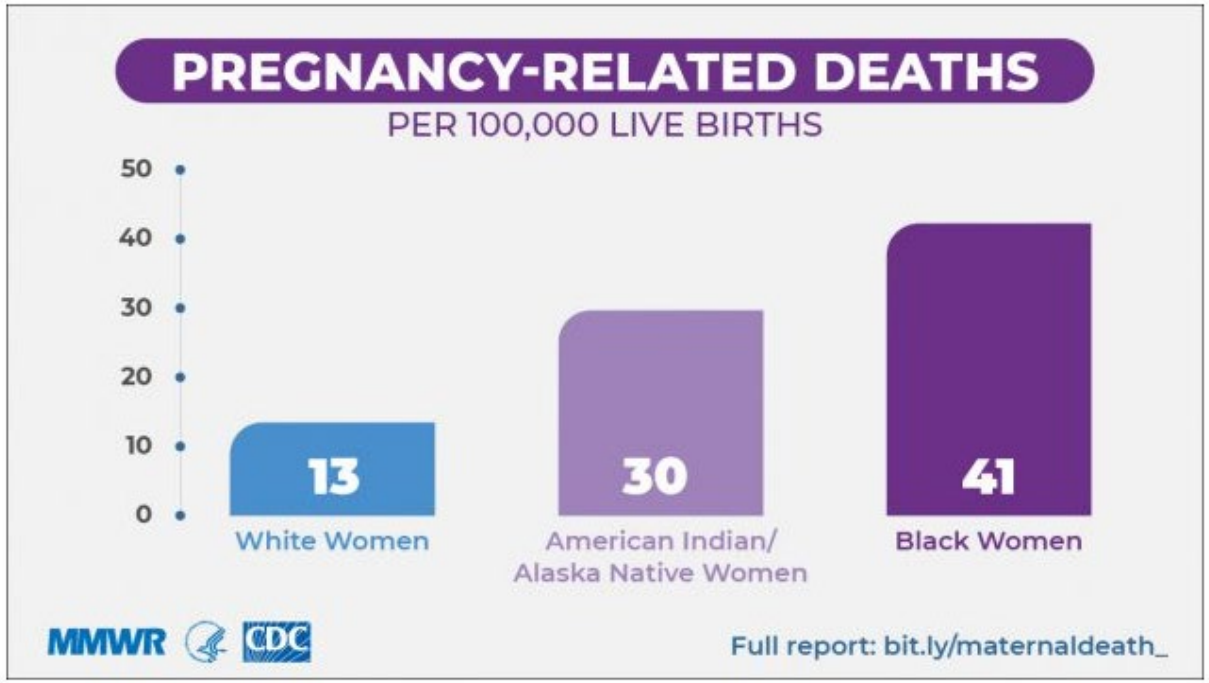


Alison Stuebe, MD, MSc, UNC @astuebe

U.S. is the only industrialized country with a rising maternal mortality rate;



Black mothers 3 to 4 times more likely to die than White mothers

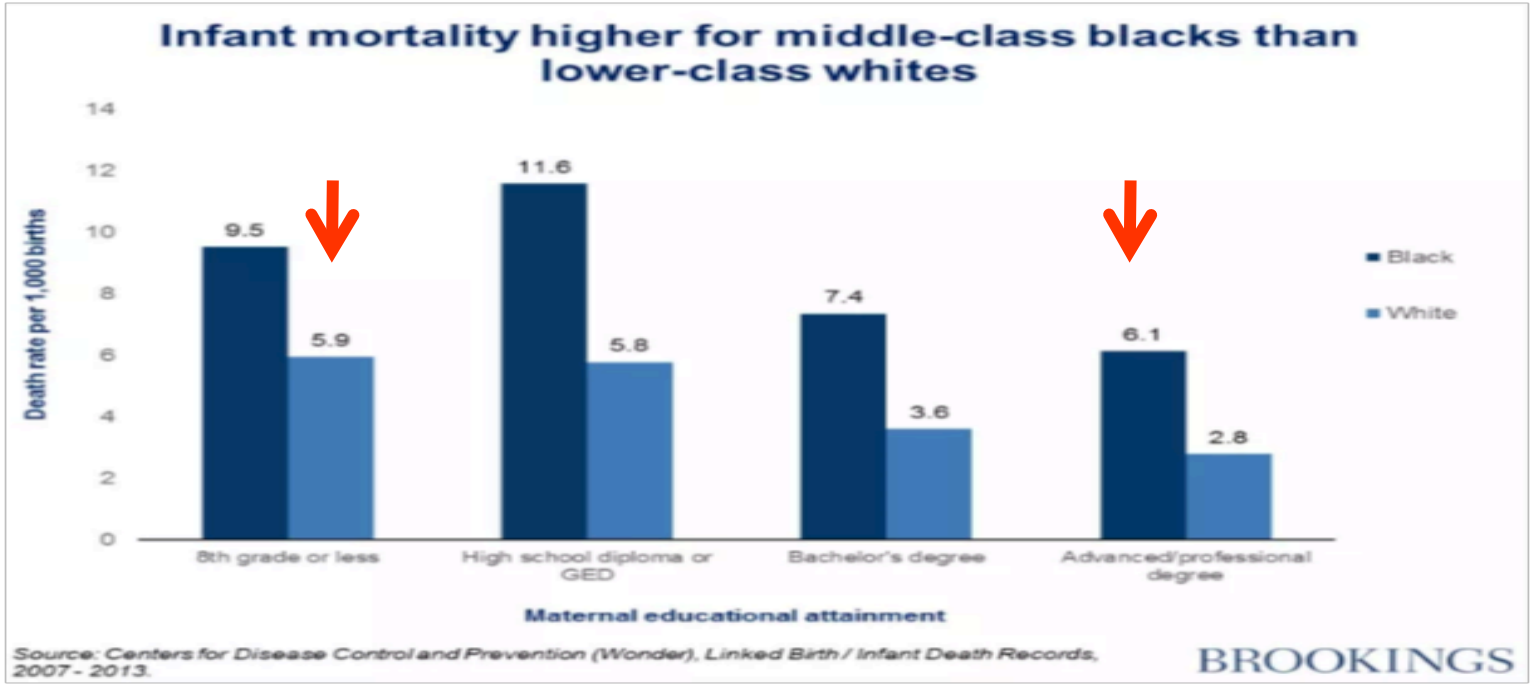


Opinion: The wealthiest Black moms are more likely to die in childbirth than the poorest white moms

Opinion by Kimberly Seals Allers

Published 6:23 PM EDT, Sat April 29, 2023

Black babies are twice as likely to die than White babies



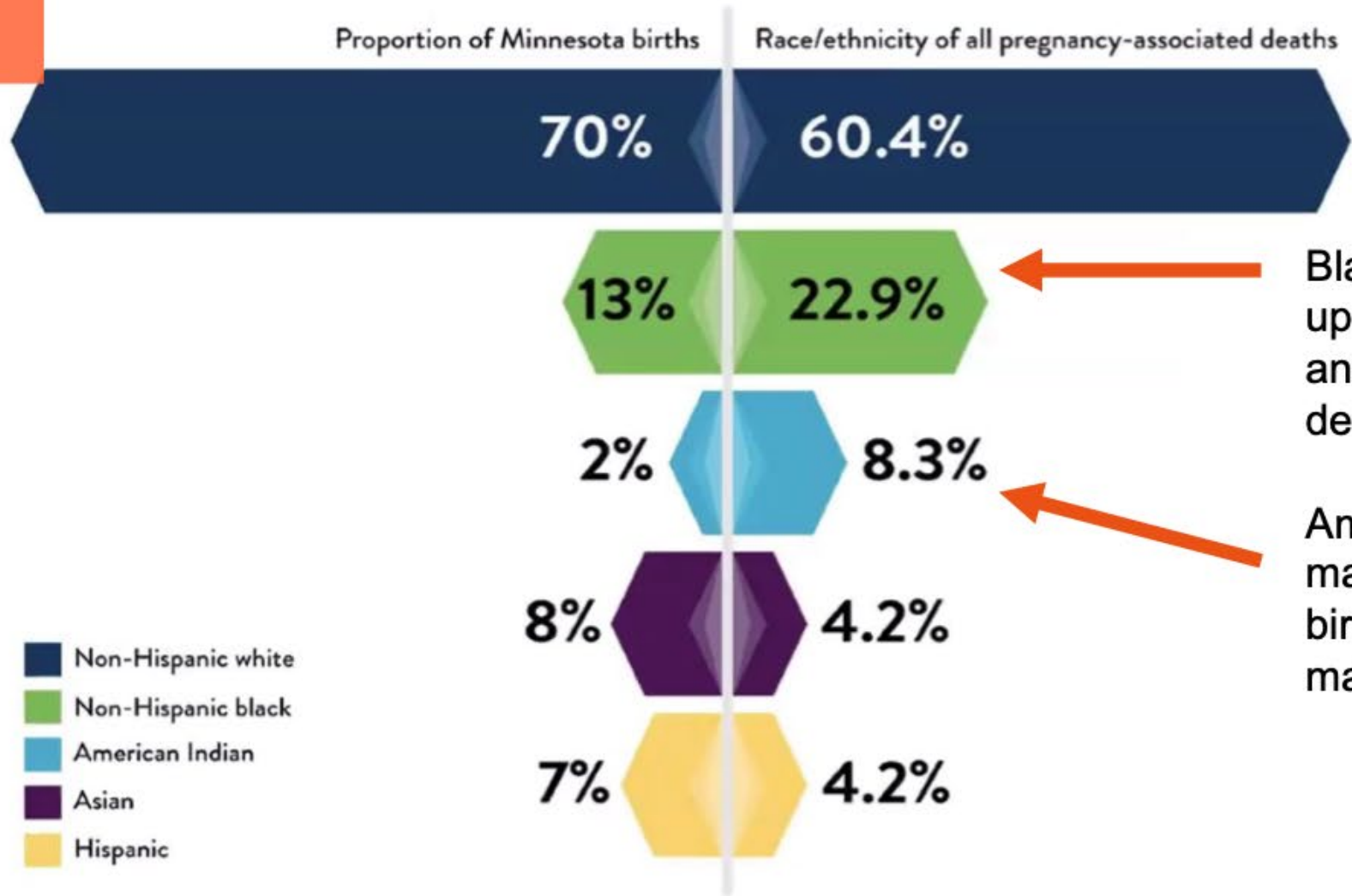
Education and poverty do <u>not</u> explain the gap in infant mortality

Black women with advanced degrees are more likely to have a baby die than a white woman with less than an 8th grade education

https://www.brookings.edu/research/time-for-justice-tackling-race-inequalities-in-health-and-housing/#_edn8

MDH's first Minnesota Maternal Mortality Report (2022)

Pregnancy Associated Deaths by Race/Ethnicity (Overall), 2017-2018

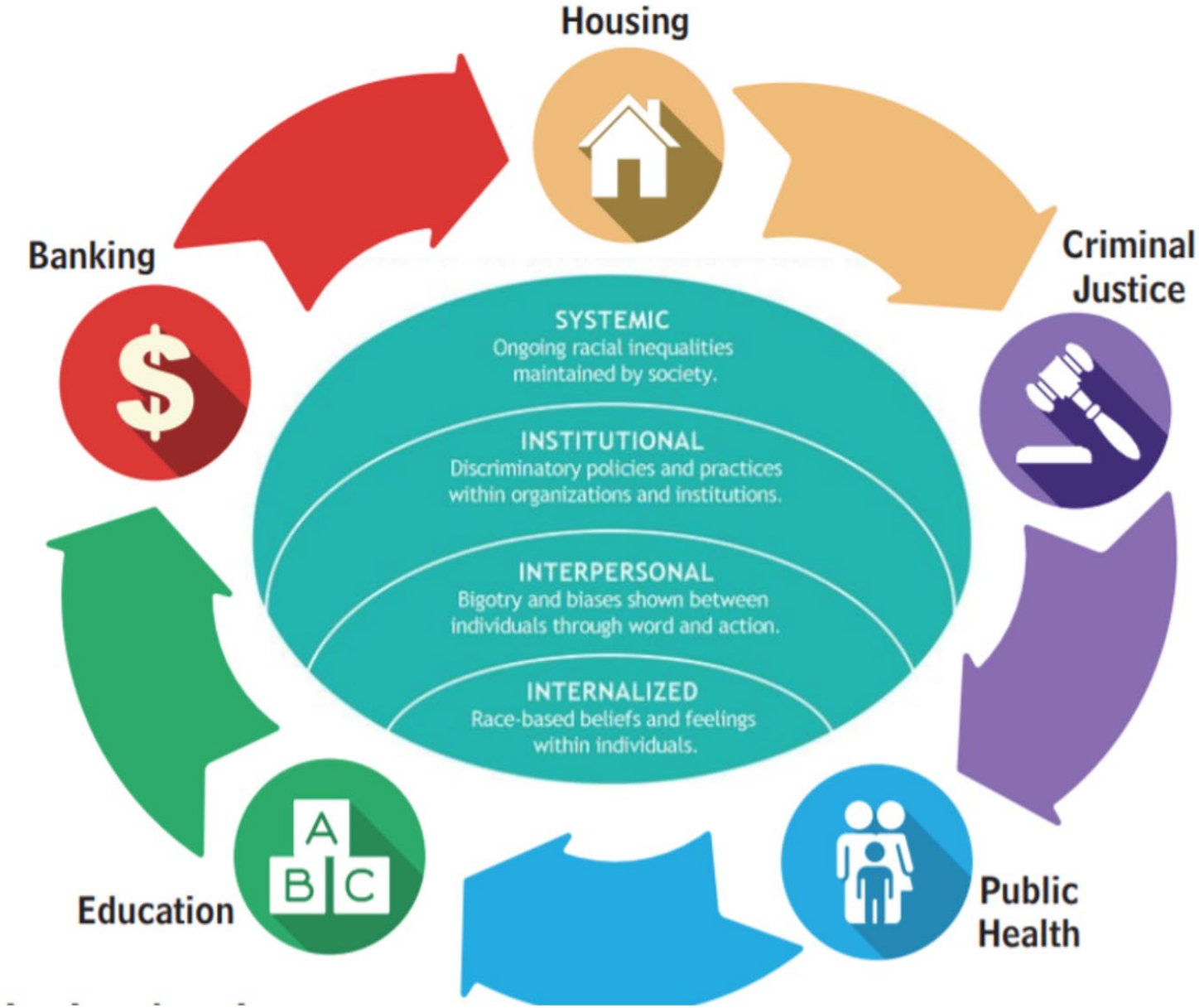


Black women make up 13% of total births and 23% of maternal deaths

Am Indian women make up 2% of total births and 8.3% of maternal deaths

DEPARTMENT OF HEALTH

Racism not race is the risk factor for maternal health, birth, child, and family outcomes



source: Frank Porter Graham Child Development Institute

CDC Press Release, Sept 19. 2022

4 out of 5 pregnancy-related deaths in the US are preventable.

- Mental health (including suicide and overdose) (23%)
- Excessive bleeding (hemorrhage) (14%)
- Cardiac and coronary conditions (relating to the heart) (13%)
- Infection (9%)
- Thrombotic embolism (a type of blood clot) (9%)
- Cardiomyopathy (a disease of the heart muscle) (9%)
- Hypertensive disorders of pregnancy (relating to high blood pressure) (7%)

www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html

“Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving”

-Mahmoud Fathallah, MD, PhD

Fathalla MF. Human rights aspects of safe motherhood. Best Pract Res Clin Obstet Gynaecol. 2006;20(3):409–419.

Objective Two

Reproductive Justice, a unifying human rights frame and a stage of healing

“If a problem can’t be solved, enlarge it.”

Dwight D. Eisenhower

Loretta J. Ross

Reproductive Justice and Human Rights Advocate
2022 MacArthur Fellow

*”When it comes to reproductive justice, when you start at the pregnancy, you’re starting at the wrong place. You have to start with what’s been going on in the person’s life **before** they got pregnant.”*

https://lorettajross.com/

https://youtu.be/sF_9VktvSPA

7.9Million women in US of reproductive age (15 to 44) are **uninsured**

https://aspe.hhs.gov/reports/health-coverage-women-under-aca

"There is no such thing as a single-issue struggle because we do not live single-issue lives."

– Audre Lorde

Intersectionality

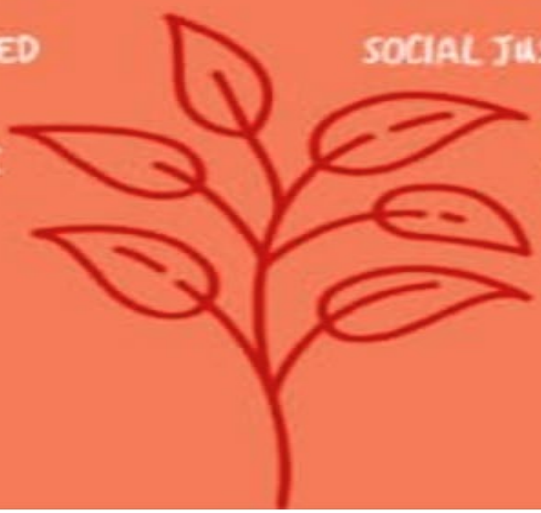
- Term coined by Dr. Kimberle Crenshaw – helped to differentiate the specific power imbalance and oppression Black women face because of race and gender
- "Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LBGTQ problem there. Many times that framework erases what happens to people who are subject to all of these things."

Reproductive justice

- 1994 -- RJ created by Black women “recognizing that the women’s rights movement, led by and representing middle class and wealthy white women, could not defend women of color and other marginalized women and people.”
- 1997 – SisterSong created as a national, multi-ethnic RJ movement.
- Today: the RJ movement includes organizations across the globe, led by Black, Indigenous, Asian American and Pacific Islander, Latine, and Middle Eastern and African women, girls, transgender and gender-expansive people.

Reproductive Rights vs. Justice

Started by white, middle-class women	Started by POC and low-income folks
Narrow scope	Intersectional
Focus on freedom to control own reproduction	Focus on freedom to control own body and parent with dignity
Seeks to secure legal rights	Seeks to dismantle barriers to access
Law-focused	Social justice-focused
Individualistic	Collectivist and structural



Learn more at sistersong.net

Reproductive Rights

Parenting Rights

Gender and Sexual Rights

Children's Rights

Patient Rights

(for health insurance, access to services)

Civil rights

Human Rights frame of **Reproductive Justice**

Reproductive Rights

Parenting Rights

Gender and Sexual Rights

Children's Rights

Patient Rights (for health insurance, access to services)

Civil rights

The human right to own our bodies and control our future

The human right to have children

The human right to not have children, and

The human right to parent the children we have in safe and sustainable communities.

https://www.sistersong.net/

Objective 3:

Where the streams meet….

<u>the Redleaf Way:</u>

***Generational healing through* integrated,**

trauma-informed, family- and healing-centered care

The Redleaf Way

Redleaf Center
For Family Healing


Reproductive Justice
Infant and Early Childhood Mental Health
Cultural Wellness
Reproductive Psychiatry
Trauma Healing

Trauma

Trauma

Physical, emotional, psychological, or spiritual injury in response to a distressing or life-threatening event like an accident, abuse, violence or natural disaster

"Too much, too soon, too fast"

Acute trauma

A single event that is time-limited

Ex: Birth Trauma

Complex Trauma

Exposure to multiple traumas that are often invasive or interpersonal and have wide-ranging, long-term impact

Ex. Childhood Abuse

Historical Trauma

The cumulative, multigenerational, collective experience of emotional and psychological injury in communities and in descendants.

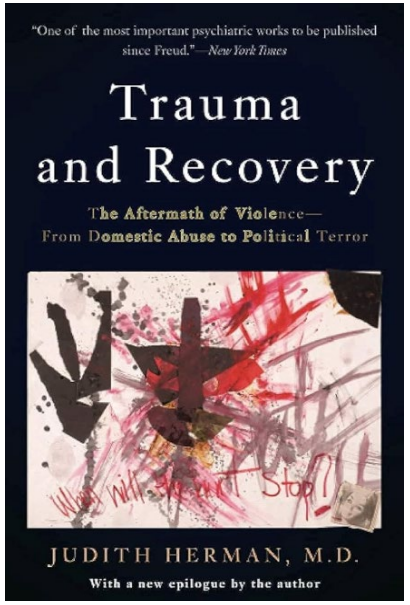
Ex. Slavery, Forced separations in Native communities

System-induced trauma

Ex. Forced medical experimentation of BIPOC communities, child separation policies that disproportionally impacted BIPOC families

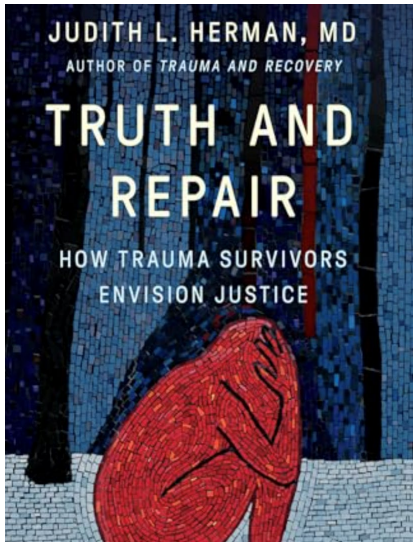
Judith Herman's Truth and Recovery (1992) – Groundbreaking. Expanded views of trauma

- Interpersonal trauma is inseparable from social and political context.
- Named Complex PTSD. Showed trauma can have enduring effects on identity and relationships
- Incorporated a feminist perspective; intersection of trauma and gender-based violence.
- Centered on survivors. Emphasized safety, trust, empowerment – seeds of TIC
- Stages of trauma healing: Safety/agency, Remembrance/Mourning, Reconnection/ Integration



Truth and Repair (2023) –

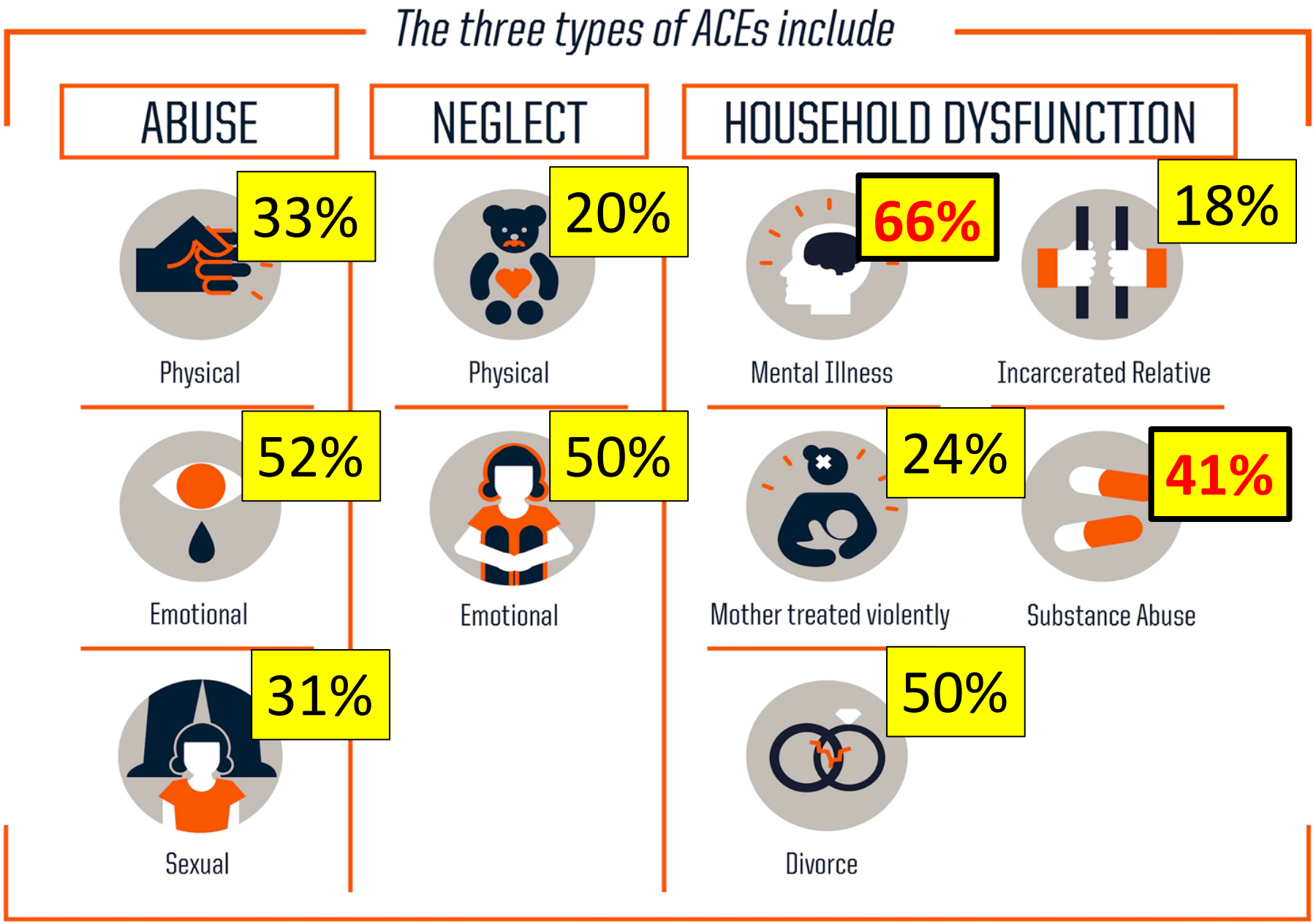
- Justice as a 4th stage of trauma healing. Asked survivors themselves – **what would justice look like? What would make this as right as possible?**
- Trauma is not just an individual issue. It's a social one. Thus, healing requires social solutions – empowerment, engagement, repair with community vs shame and silence.
- Acknowledgement, Apology, Amends
- Possible repair with bystanders and community, maybe new community?
- **For survivors, how do we bear witness and support steps toward felt justice?**

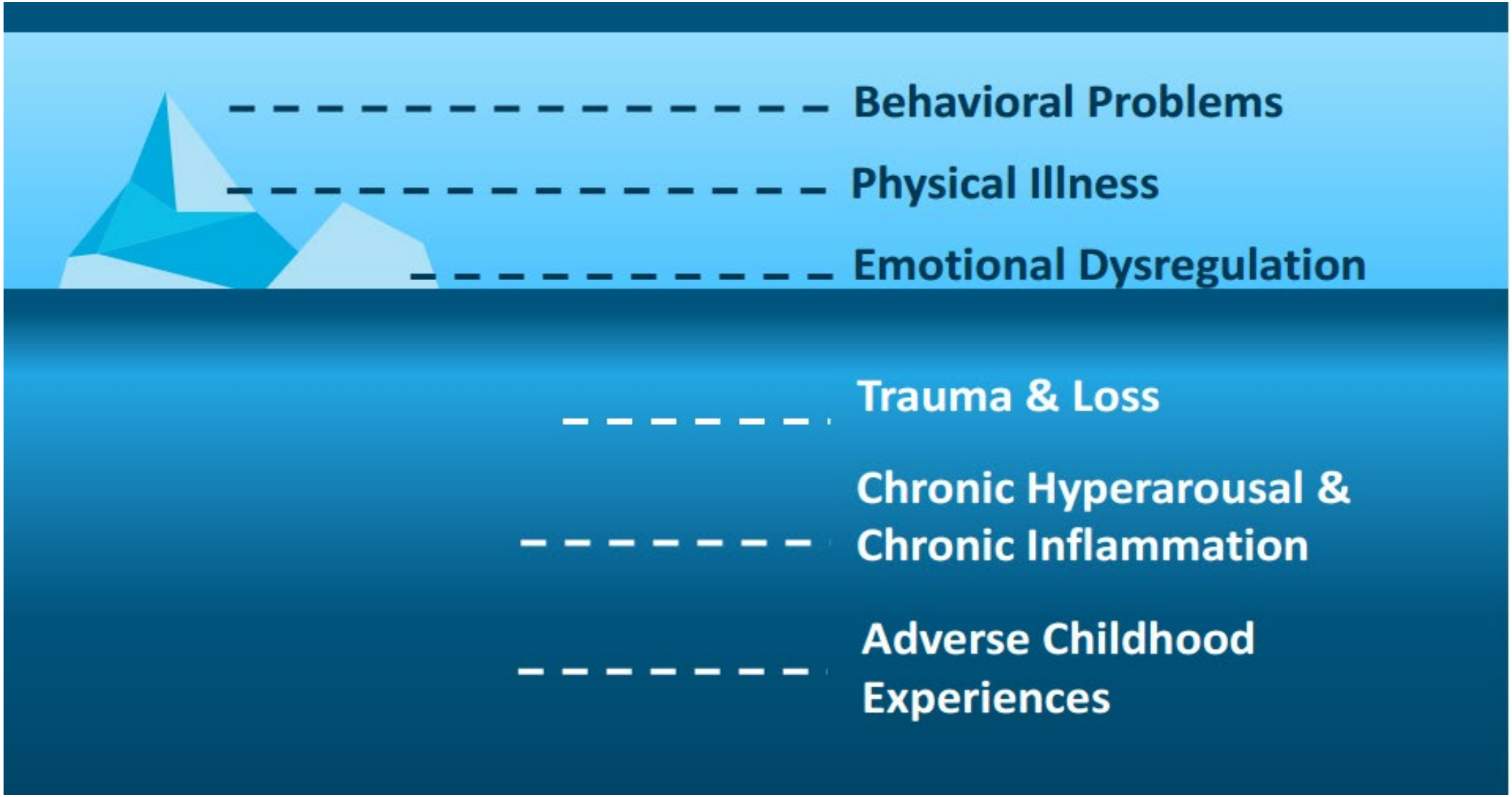


REDLEAF CENTER
FOR FAMILY HEALING

Maternal ACEs: Generational healing opportunities

Mean #ACEs = 3.9

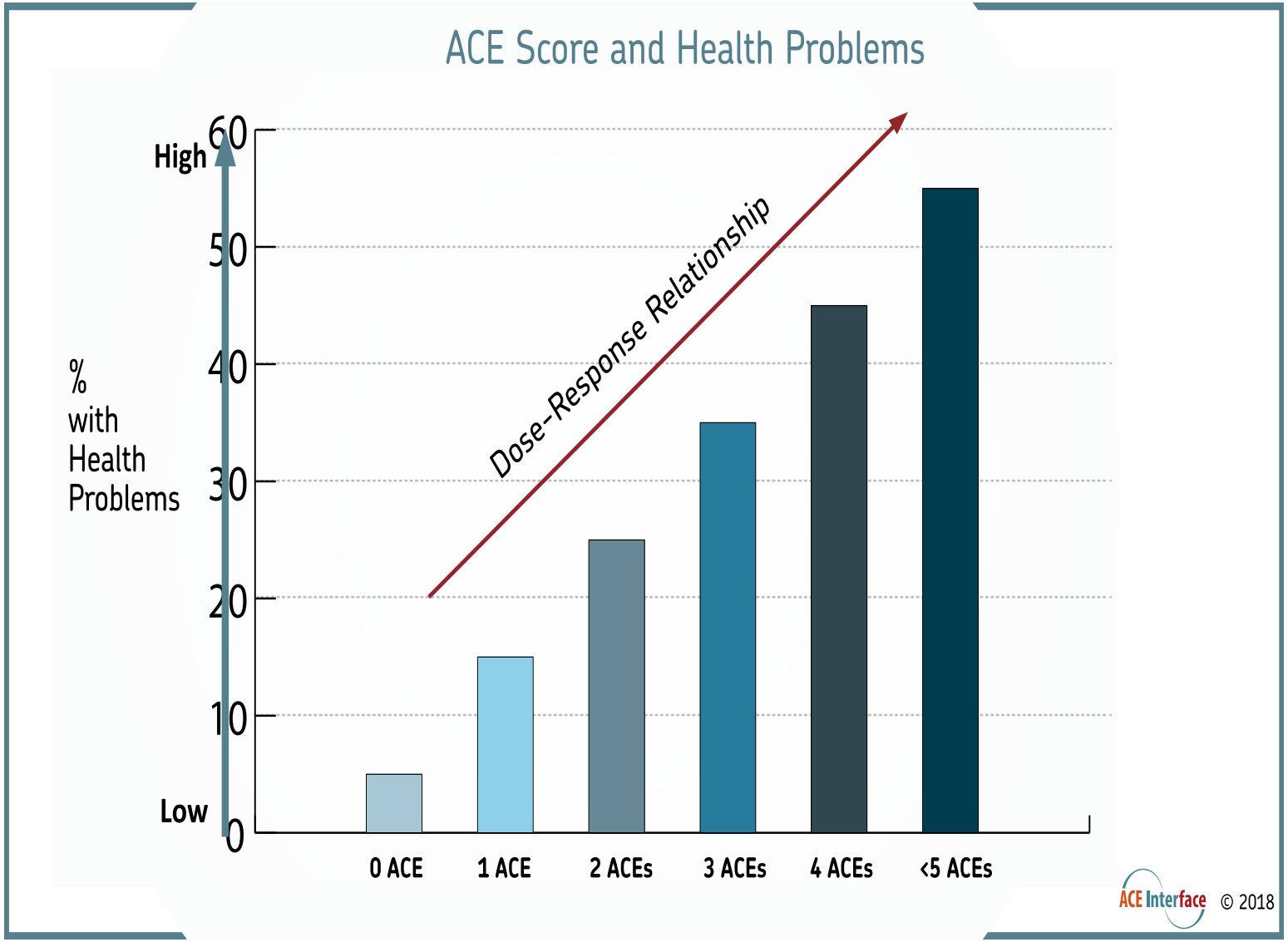




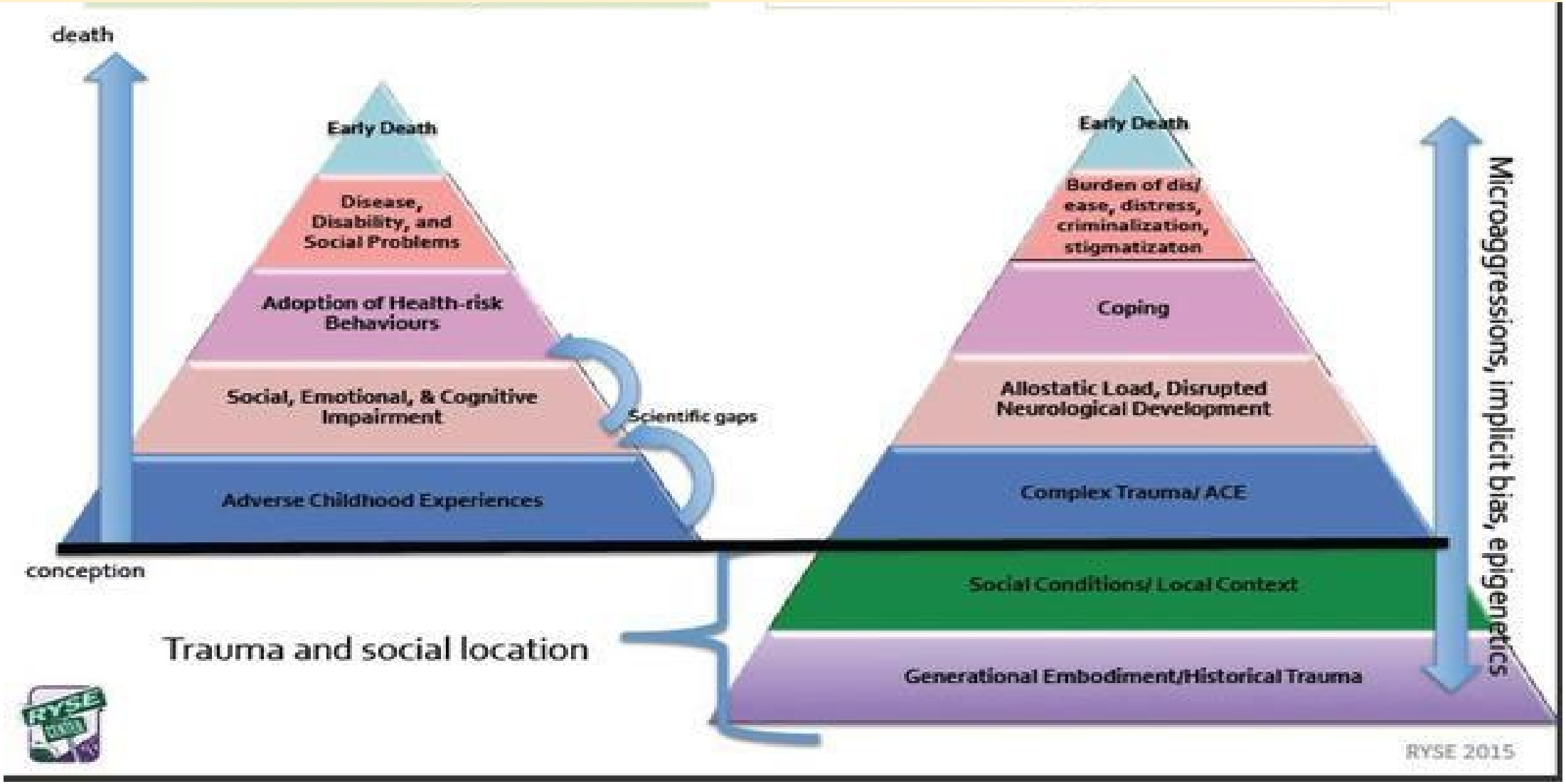
Toward a Trauma-Informed Philadelphia, Sandra Bloom 2016

Findings from original ACEs and subsequent studies:

- ACEs are common
- ACEs are associated with poor adult health
- ACEs are associated with profound negative effects well-being, social problems, early death



Beneath and infused throughout the ACEs pyramid….
Historical Trauma, Systemic Racism, Implicit Bias



Early adversity can last a lifetime and impacts adult health, education, financial and social stability

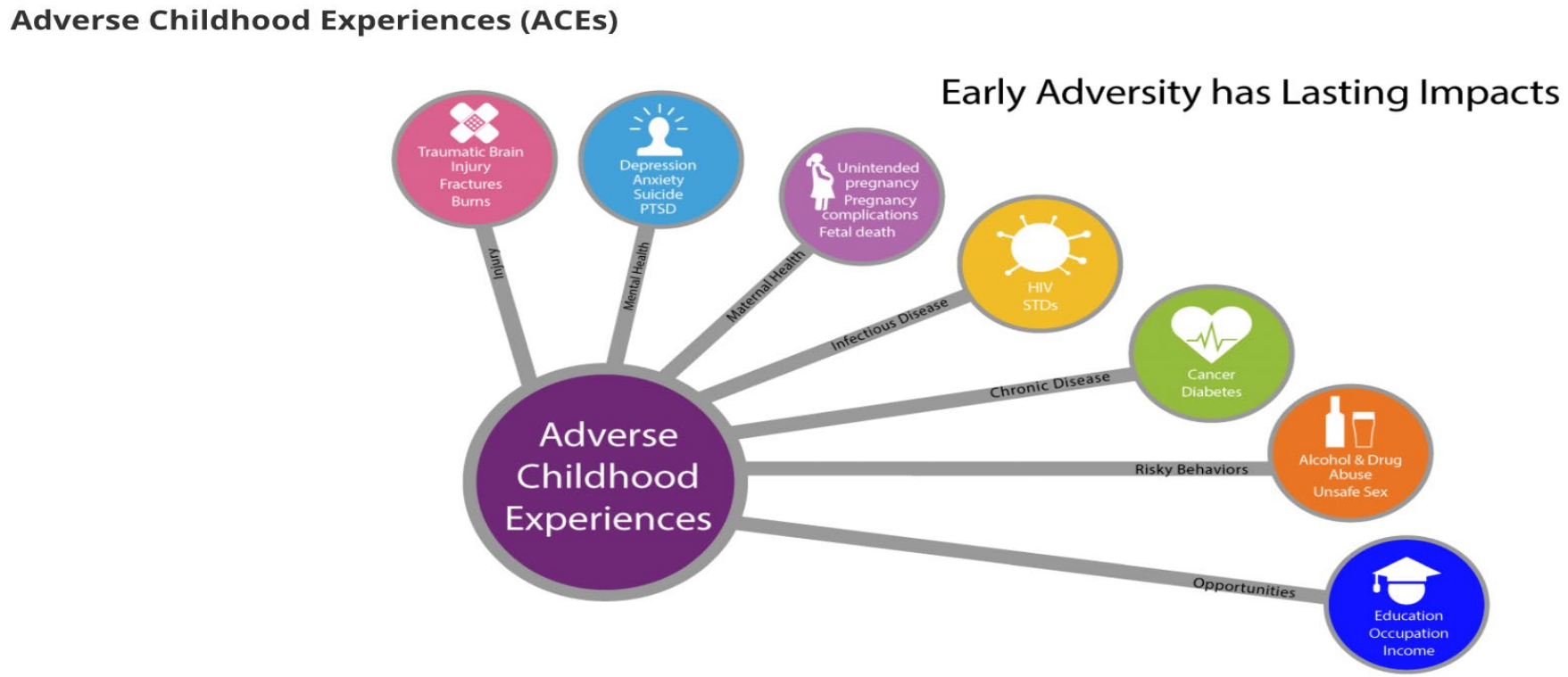


Figure 1. Linking Adverse Childhood Experiences to health behaviors. From the Centers for Disease Control and Prevention. 2019. https://www.cdc.gov/violenceprevention/acestudy/resources.html?

where the streams meet: opportunities for generational healing

Parents' urgent mental health needs

Children's urgent developmental needs

Redleaf Center
For Family Healing

Positive Childhood Experiences (PCEs) and PACEs.

If you have a high ACE score, are you doomed? NO!

The brain is “plastic” and changes in response to the environment.

One can heal and build resilience through decreasing toxic stress and increasing health-promoting practices.

Evidence for mindfulness practices, exercise, good nutrition, adequate sleep, and healthy social interactions

WE ARE MORE THAN OUR ACEs and more than the bad things that have happened to us.

JAMA Pediatr. 2019 Nov 1;173(11):e193007. doi: 10.1001/jamapediatrics.2019.3007.
Epub 2019 Nov 4.

Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels

Christina Bethell [1], Jennifer Jones [2], Narangerel Gombojav [1], Jeff Linkenbach [3], Robert Sege [4]

Dr. Robert Sege, HOPE in 2021 and Beyond: Spreading HOPE, 4/15/2021

https://www.youtube.com/watch?v=-BT0pMHmiag

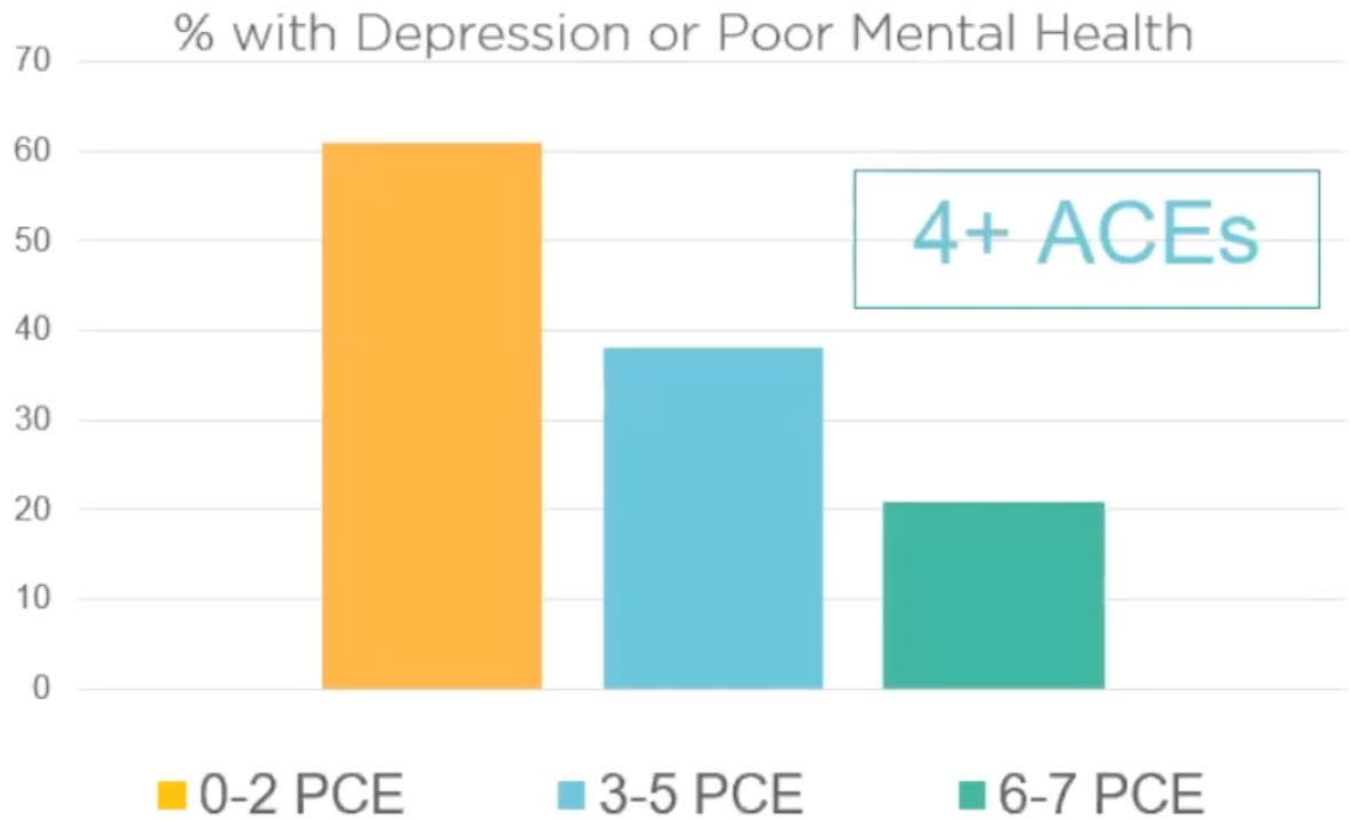
Positive Childhood Experiences Scale

1. Felt able to talk to their family about feelings
2. Felt their family stood by them during difficult times
3. Enjoyed participating in community traditions
4. Felt a sense of belonging in high school
5. Felt supported by friends
6. Had > 1 non-parent adults who took genuine interest in them
7. Felt safe and protected by an adult in their home

HOPE

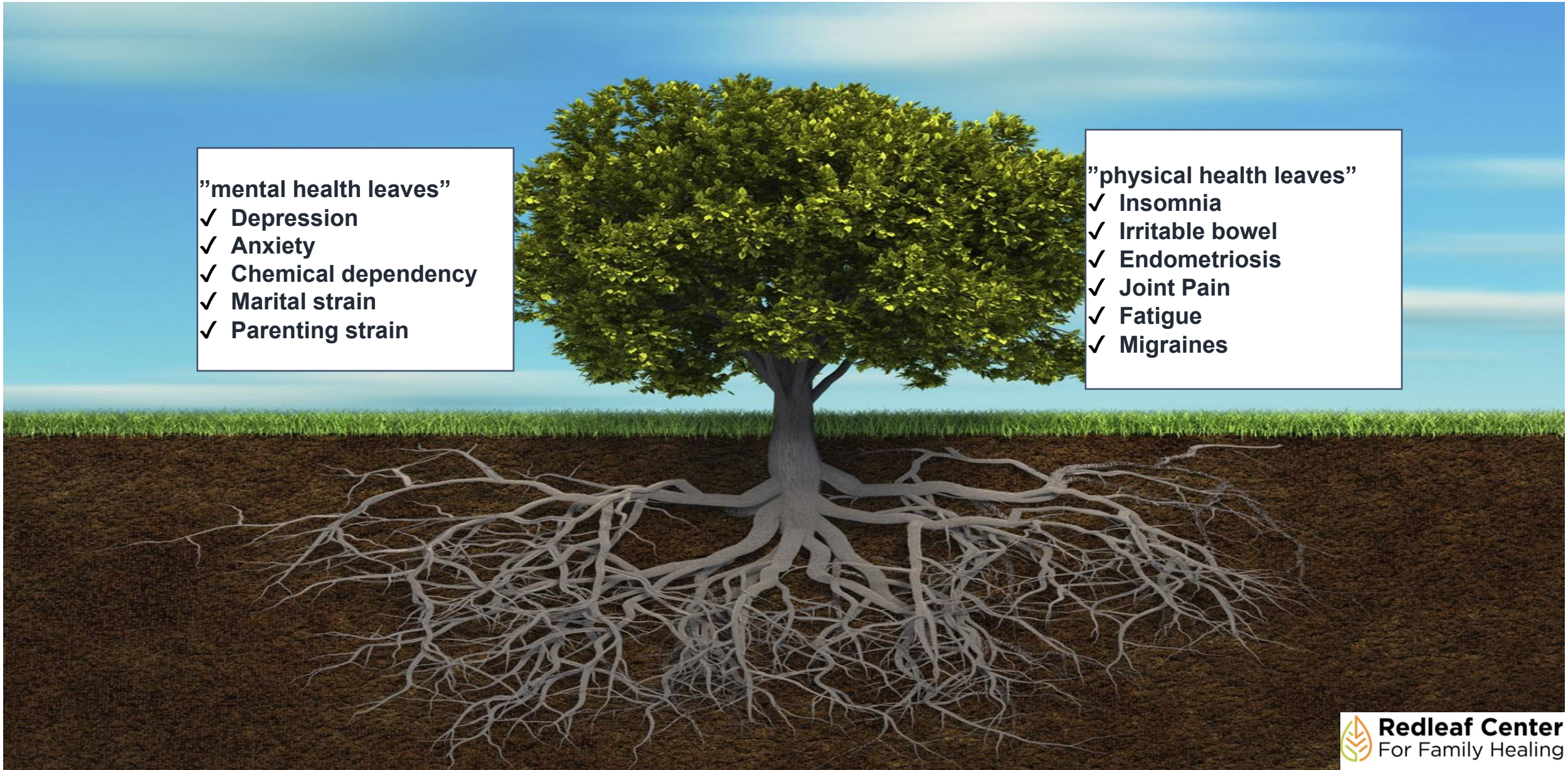
Sege, Bethell, Linkenbach, Jones, Klika and Pecora. Balancing ACEs with HOPE: New insights into the role of Positive Experiences on Child and Family Development. Casey Family Programs, 2017

Positive Childhood Experiences Mitigate ACEs Effects



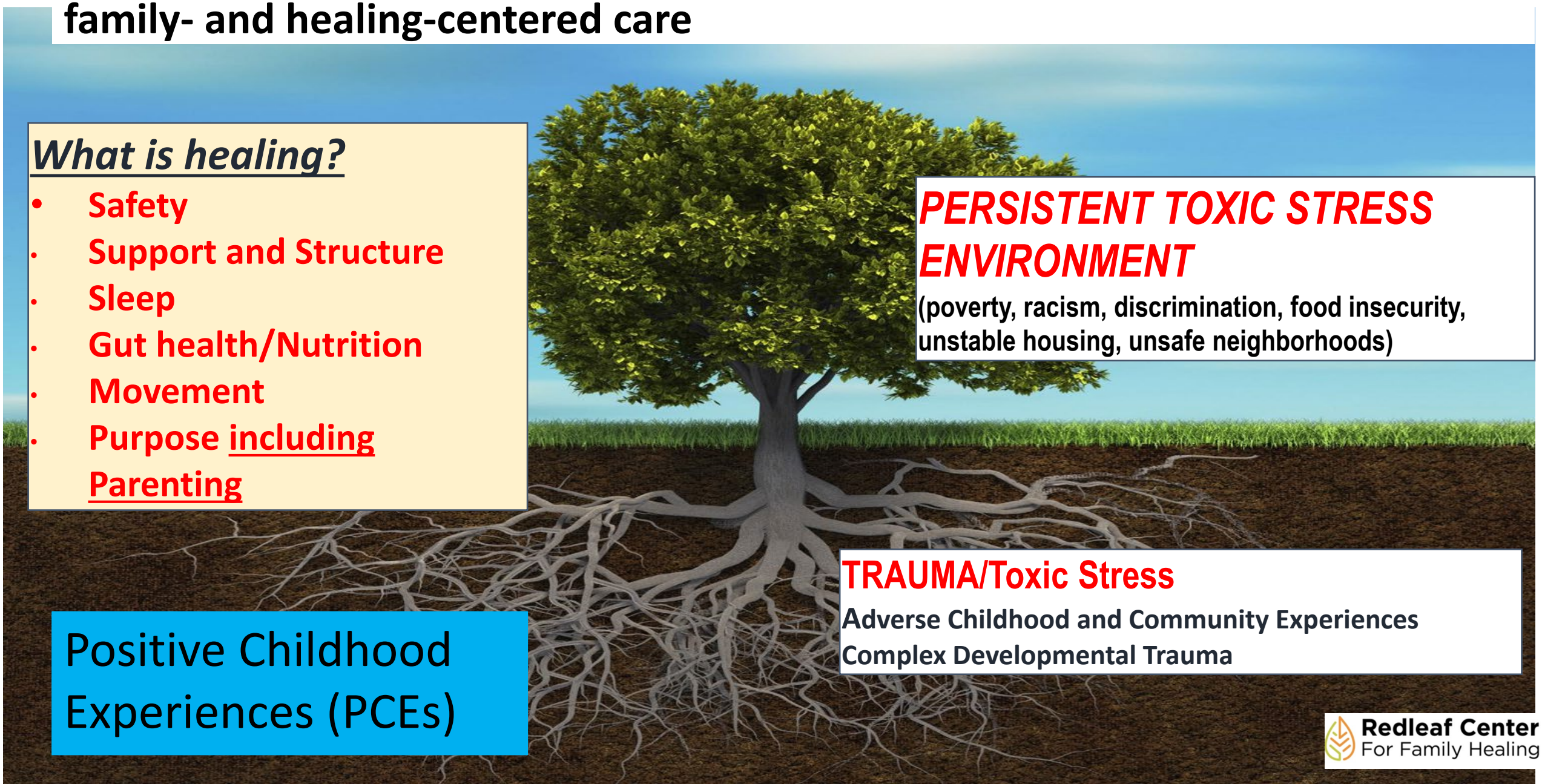
Bethell C, Jones J, Gombojav N, Linkenbach, Sege R, Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels, JAMA Pediatr. 2019; e193007

Traditional leaf approach to healthcare



Redleaf Center
For Family Healing

The Redleaf Way: generational healing through integrated, trauma-informed, family- and healing-centered care



What is healing?

- Safety
- Support and Structure
- Sleep
- Gut health/Nutrition
- Movement
- Purpose <u>including Parenting</u>

PERSISTENT TOXIC STRESS ENVIRONMENT

(poverty, racism, discrimination, food insecurity, unstable housing, unsafe neighborhoods)

TRAUMA/Toxic Stress

Adverse Childhood and Community Experiences
Complex Developmental Trauma

Positive Childhood Experiences (PCEs)

Redleaf Center For Family Healing


Reproductive Justice
Infant and Early Childhood Mental Health
Cultural Wellness
Reproductive Psychiatry
Trauma Healing

Cultural Wellness

- Research confirms that a strong cultural identity can buffer stress and bolster self-esteem and well-being.

- These strengths are represented in the Positive Childhood Experiences screening tool (i.e. participation in community traditions, sense of belonging, strong family relationships).

- The Cultural Wellness field provides enormous opportunity to utilize and cultivate cultural strengths to support healing. This has been called the “ordinary magic” of family well-being (Masten, 2015; Murry et al., 2018; Tyrell & Masten, 2021).

Cultural Forumlation

Inpatient formulation:
18 y.o. female with past psychiatric history significant for major depressive disorder, generalized anxiety disorder, PTSD, borderline personality traits, unspecified dissociative disorder, conversion disorder by history, and psychogenic non-epileptic seizures by history.

Mother-Baby Day Hospital formulation:
Brave, caring, resourceful 18 y.o. Mexican mother of a 1 month old. She immigrated from Mexico at age 4 and endured pre-immigration community trauma, and continued post-immigration toxic stress. Clinical symptoms are consistent with Complex Developmental Trauma (history of cumulative trauma during childhood with inadequate adult nurturance and protection resulting in struggles with self-regulation, attachment, anxiety, and relationships). She presents now following recent psychiatric admission for "Postpartum Psychosis" in the setting of a traumatic full term birth via C-section 1 month ago, limited support and nurturance. In addition, she describes an oppressive situation which she eloquently describes as being "caught between cultures" of her cultural and family expectations, her mother's domineering presence and her own emerging self-agency that is developmentally appropriate at her age and yet remarkable given her felt experience of invisibility in her family and in the white supremacist culture of the US.

She is organized, clear and has no current signs of psychosis though continues to have low mood and has had past episodes consistent with hypomania and suggestive of bipolar spectrum (versus unipolar depression). She has many strengths including her warmth, intelligence, and strong drive to parent well. Nonetheless she continues to need support and meets criteria for the Mother Baby Day Hospital and requires the structure, support and education that the program can provide.

Cultural Humility Framework

- Shift from *Cultural Competence* to *Cultural Humility*

- The National Institutes of Health (NIH) defines cultural humility as

"a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities."

- The term was first coined in 1998 by healthcare professionals Melanie Tervalon and Jann Murray-García.

Increasing Awareness of Privilege and Power

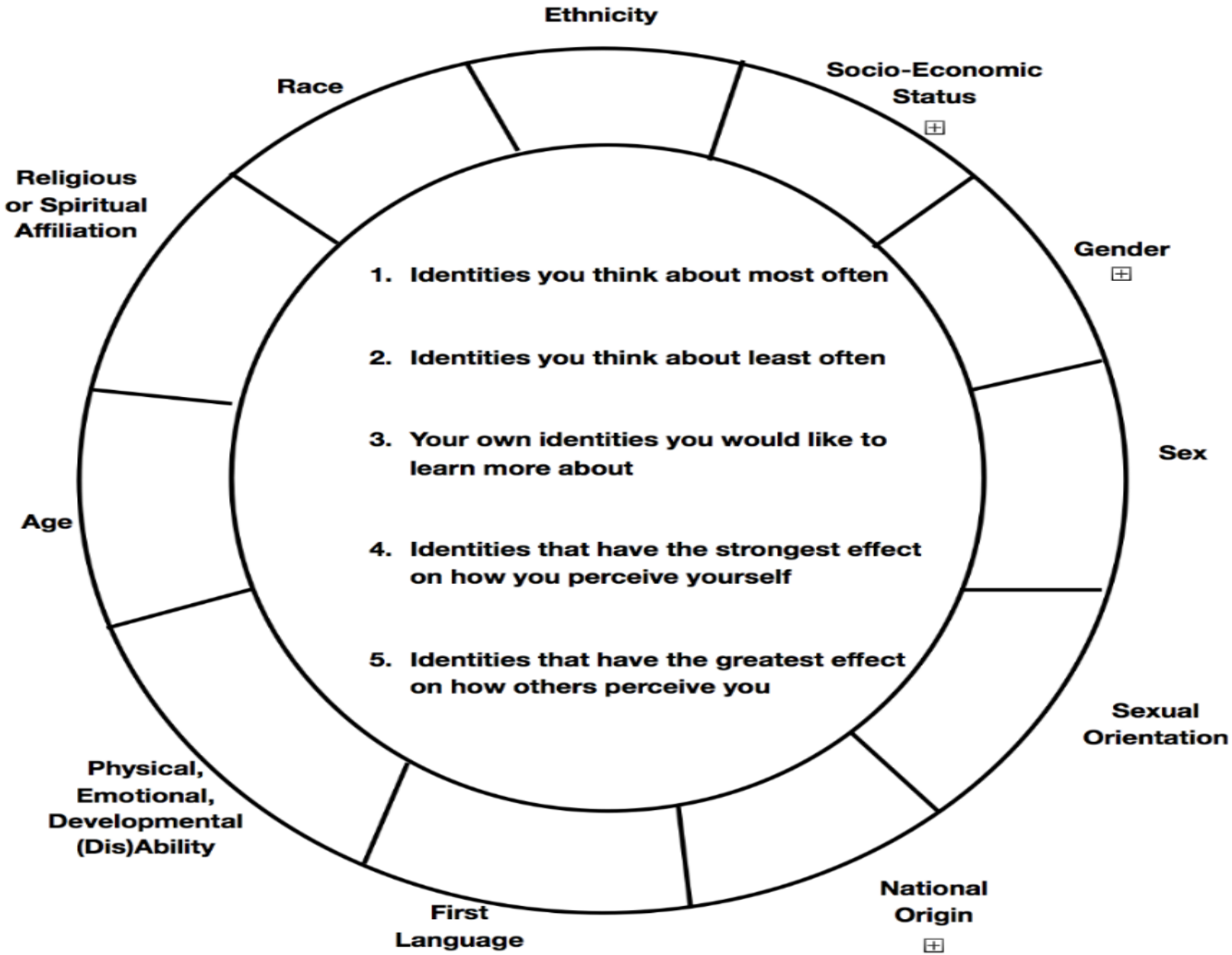
- Privilege: Rights, special benefits or advantages that are enjoyed by a person or a group of people that others do not have access to.
- Power: People with privilege often are in a position to use power over others who are less privileged.

What privilege do I hold? Positional, language, gender, sexual identity, socioeconomic, racial, etc.

How can I utilize my privilege in ways that support my work/families?

How can the privilege/power I hold unintentionally harm?

Activity: Cultural Autobiography



Other Identities:

In what ways do these identifies impact your work?

Self-Reflection Activity

What do I feel like when I am doing well? How do I take care of myself?	What was my own experience of being parented?
What strengths and vulnerabilities do I have in my social context now and when I was growing up?	What are my beliefs about children and parenting?

How do these/could these components impact my work?

Reproductive Psychiatry


Reproductive Justice
Infant and Early Childhood Mental Health
Cultural Wellness
Reproductive Psychiatry
Trauma Healing

Perinatal Mental Health

- Perinatal Mental Health refers to mental health during pregnancy and the postpartum period (typically defined as 1 year postpartum);

- Research affirms that perinatal mental illness is common and can have significant negative impacts not only on women, but their children and families as well;

- Reproductive Psychiatry refers to the psychiatric treatment of individuals during reproductive transitions (times characterized by hormonal flux and/or social role change)

Redleaf Center
For Family Healing

Myths of Pregnancy/Motherhood

Perinatal Context

- “This is an illness that takes away the ability to access joy, right at the time when the parent needs it the most.” (Dr. Katherine Wisner)

- Gap between the reality of what happened and the hoped for conception, pregnancy, delivery, postpartum, and breastfeeding experience

- Intense time of vulnerability and responsibility
  - Two questions parents have: How am I doing? How is my baby doing?

- Developmental transition

Prevalence

- Up to 25% of pregnant and postpartum individuals will experience perinatal depression
- In Minnesota in 2019, the % of new moms who self-reported PPD was 11%
  - For African-American moms it was 17.9%
  - For Native moms it was 23.6%
- It has been called the most common complication of childbirth (Wisner)

Spectrum of Disorders

- ***We are required to be diagnosticians and yet, how can we approach our clients from place of distress versus disorder?***

Mood Disorders	Anxiety Disorders	Trauma-Related	Psychotic	Other
Major Depression Dysthymia Bipolar I Bipolar II Cyclothymia	Generalized Anxiety OCD Panic Disorder	PTSD Complex Trauma (*Other Specified Trauma- and Stressor-Related)*	Postpartum Psychosis	Personality disorders Substance-related

Trauma is to mental illness what smoking is to lung cancer.

Perinatal Mental Health and Trauma

- Common and often overlooked in field of perinatal mental health that tends to focus on depression and anxiety
- Common diagnoses in the Mother-Baby Program include PTSD and Complex Trauma
- Comorbidity of mood and anxiety related disorders and trauma is common for women admitted to MBDH
    - 75% of women admitted to MBDH had history of 3 or more conventional ACES, 90% had at least 1

Redleaf Center
For Family Healing

Pregnancy

- 50% of women with PPD have depression during pregnancy (Neter 1995; Johnstone 2001; Josefsson 2002)
- Pregnant women have a 36% increased risk of experiencing violence compared to women who are not pregnant (Gelles, 1988)
- Negative attributions towards unborn child tend to persist postpartum without intervention (Huth-Bocks et al, 2004)

Fathers and Postpartum Depression

- 10% of men experience postpartum depression (JAMA 2010), comorbid anxiety common

❖ Common symptoms for men include:

  - ❖ Frustration
  - ❖ Irritability
  - ❖ Agitation
  - ❖ Increase in drinking, drugs, gambling
  - ❖ Isolation
  - ❖ Restricted range of emotion
  - ❖ Indecisiveness

❖ EPDS can be used, but lower cut off score often used

❖ If father cannot be directly assessed, EPDS-Partner can be used (mother answers about her partner)

LGBTQ and Perinatal Mental Health

- Most research has focused on cisgender, heterosexual women
- Strong evidence for mental health disparities associated with minority sexual orientation in the general population (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006; Cochran & Mays, 2007)
- Risk factors including stigma, discrimination, fertility concerns
- PSI Queer and Trans Parent Support Group
  - https://www.postpartum.net/get-help/queer-parents/

What causes Perinatal Mental Health Disorders?

- No consistent correlation with hormone shifts however some women may be more sensitive to these shifts
- Risk factors:
  - **Insomnia** is one of the most consistent risk factors for postpartum psychiatric decompensation and must be treated aggressively
  - **Lack of social support**
  - **Personal or family history of mental illness or trauma**
  - **Recent stressful life events**
  - Difficult infant temperament
  - Childcare stress
  - Single marital status
  - Lower socioeconomic status
  - Unplanned or unwanted pregnancy

Perinatal Mental Health Treatment

- Psychotherapy: Interpersonal Therapy (IPT) and Cognitive-Behavioral Therapy (CBT) have most robust evidence base in perinatal population
  - Findings more mixed when applied in low-income, BIPOC populations (Nillni et al, 2018)
  - Consider Exposure and Response Prevention for Perinatal OCD
- Medications:
  - Counseling women on whether to continue medication during pregnancy/lactation includes assessing the risks and benefits of the medication as well as the risks related to the illness.
- Combination of psychotherapy and medication in moderate-severe episodes
- Prioritize sleep and support

THE PERFECT POSTPARTUM STORM:

+U.S. CULTURAL AND SOCIAL CONTEXT
+POLICIES THAT FAIL TO SUPPORT FAMILIES
+HIGH RISK TIME FOR PARENTAL DISTRESS
+CRITICAL WINDOW OF CHILD DEVELOPMENT

"Postpartum depression is an illness that takes away a mother's ability to access joy when babies need it the most."
Katherine Wisner, MD

Up to **1 in 5** of those who are pregnant and in the postpartum period will suffer from a maternal mental health disorder like postpartum depression [1]

Less Than 15% receive treatment [2]

1 in 7 will experience depression during pregnancy [3]

Up to **50%** living in poverty will suffer from a maternal mental health disorder [4,5]

Not Just Moms

Maternal mental health disorders impact the whole family [6]

More Than 600,000 will suffer from a maternal mental health disorder in the U.S. every year [7]

Anxiety and depression have risen **37%** in teen girls

This will increase the number suffering postpartum depression in the future [5]

Rates of Depression are more than **Doubled in the Black Population**

Due to cumulative effects of stress called "weathering" [8]

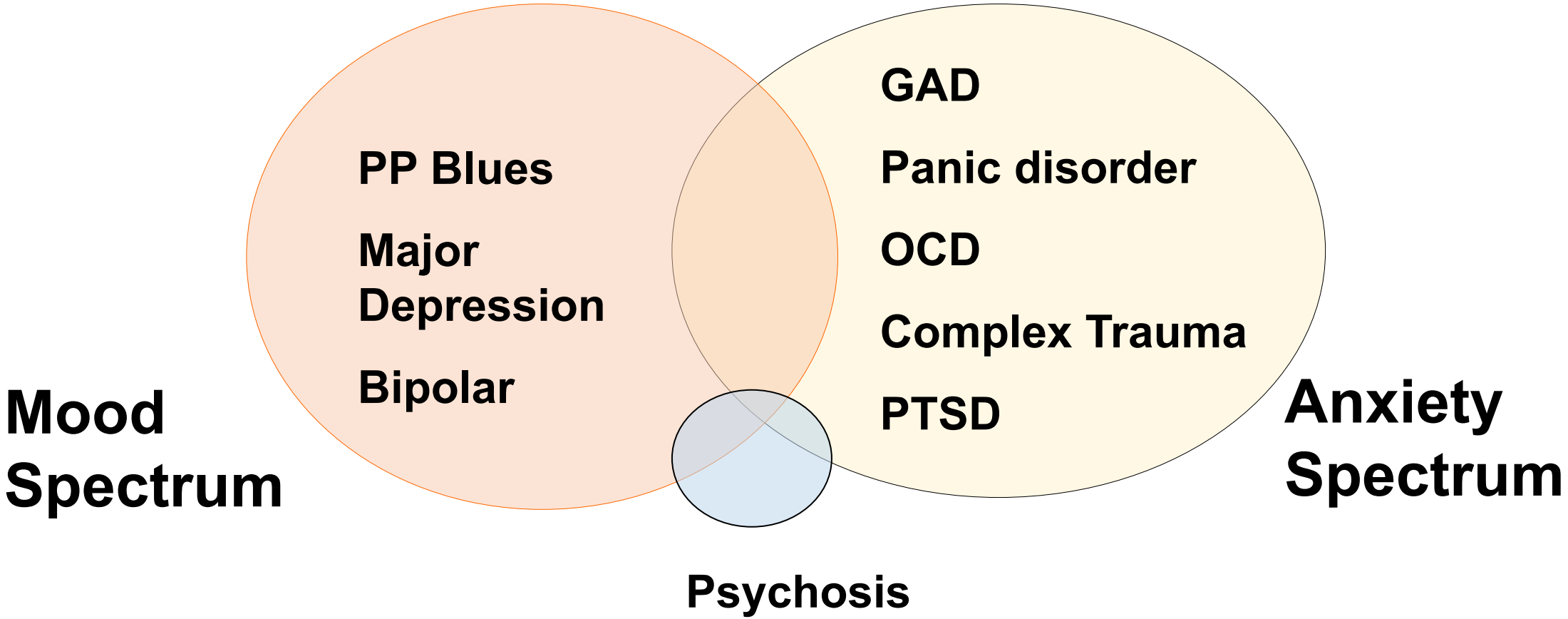
20/20 mom

Visionaries for the Future of Maternal Mental Health

2020Mom.org

View citations at: 2020mom.org/mmh-infographic-citations

Perinatal (prenatal+postpartum) Mood and Anxiety Disorders



Redleaf Center For Family Healing

Bipolar Disorder and Risk

- Most people with bipolar disorder in the outpatient setting are initially seen for—and diagnosed with—unipolar depression
- Important to screen for history of Manic/hypomanic symptoms, family history of bipolar • Incorrect treatment for bipolar disorder can actually lead to episodes of mania
- Women with Bipolar Disorder are in particular at very high risk for relapse in the postpartum period.
- It appears that in most cases, postpartum psychosis represents an episode of bipolar illness. (NCRP)

Intrusive Thoughts

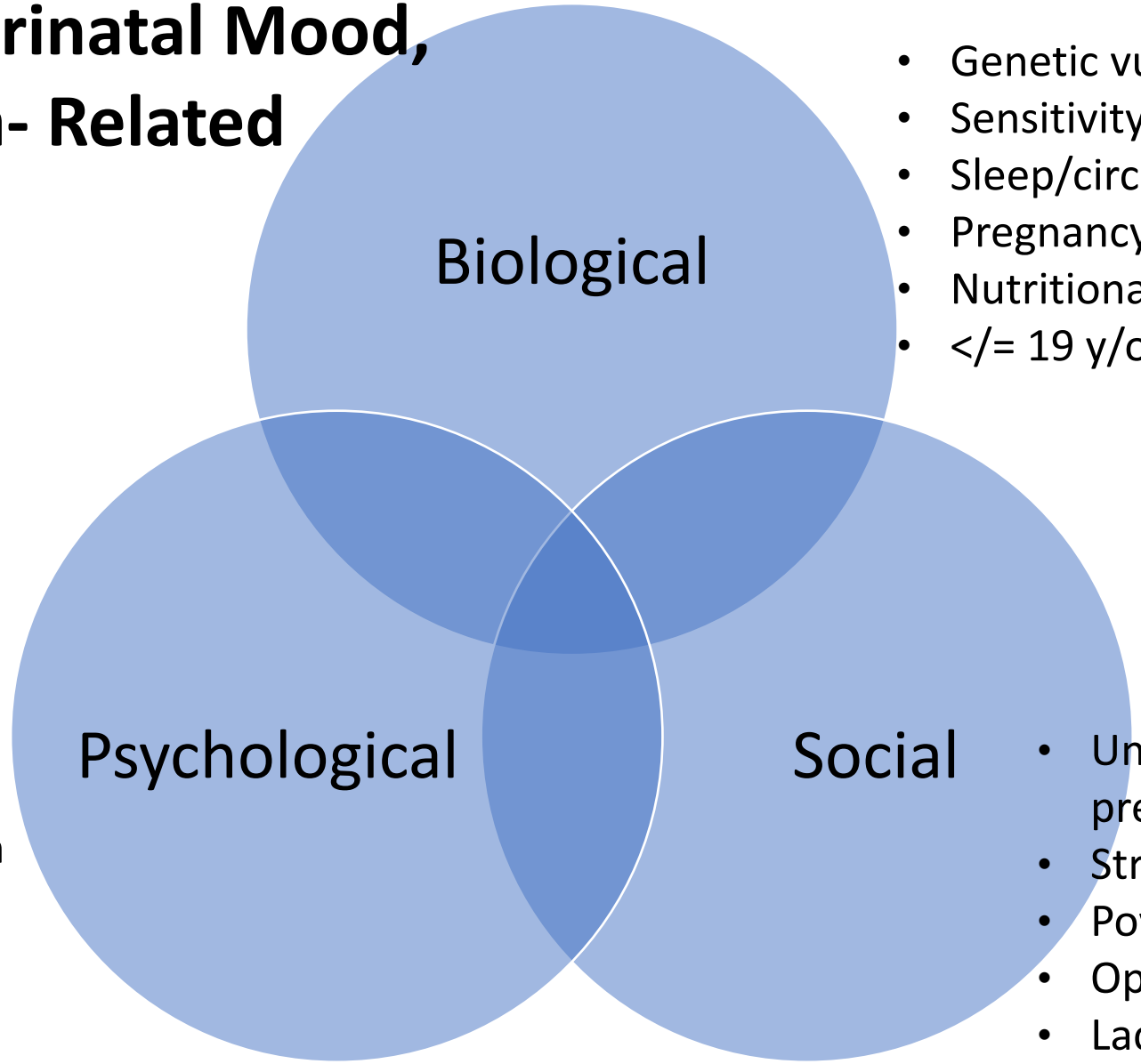
- Intrusive thoughts are **unwanted thoughts, images, impulses, or urges that can occur spontaneously or that can be cued by external/internal stimuli**.

- Between 70 and 100% of new mothers report unwanted, intrusive thoughts of infant related harm with as many as half of all new mothers reporting unwanted, intrusive thoughts of harming their infant on purpose (Fairbrother et al, 2008)
- They do not, however, reflect the person's actual wishes or intentions

Postpartum Psychosis – A Psychiatric Emergency

- Rare – only 1 in 1000 – risks include suicide and infanticide (1-4.5%)
- Rapid onset (hours/days) and usually within 3-14 days of childbirth, waxing and waning quality
- Mood symptoms, psychosis, and cognitive disorganization
- Early signs may include: unexplained decline in functioning, social withdrawal, increased suspiciousness, new or unusual preoccupation with religious themes.
- **Women should not be left alone and should be followed room to room.**

Risk Factors for Perinatal Mood, Anxiety, & Trauma- Related Disorders



- Genetic vulnerability
- Sensitivity to hormonal changes
- Sleep/circadian rhythm changes
- Pregnancy complications
- Nutritional deficits
- </= 19 y/o

- Coping skills
- Self-esteem
- Hx of Depression
- Hx of Anxiety
- Trauma history

- Unplanned or unwelcomed pregnancy
- Stressful life events
- Poverty
- Oppression/Racism
- Lack of support
- Single parenting
- <12 yrs education

Miller et al. Psychiatr Clin N Am 2011

USPSTF. *JAMA* 2019. Miller et al. *Psychiatr Clin N Am*

Barriers to Treatment

Patient

Stigma/Fear

Lack of detection

Limited Access

Under-resourced

Provider

Lack of training

Not enough time

Discomfort

Limited resources

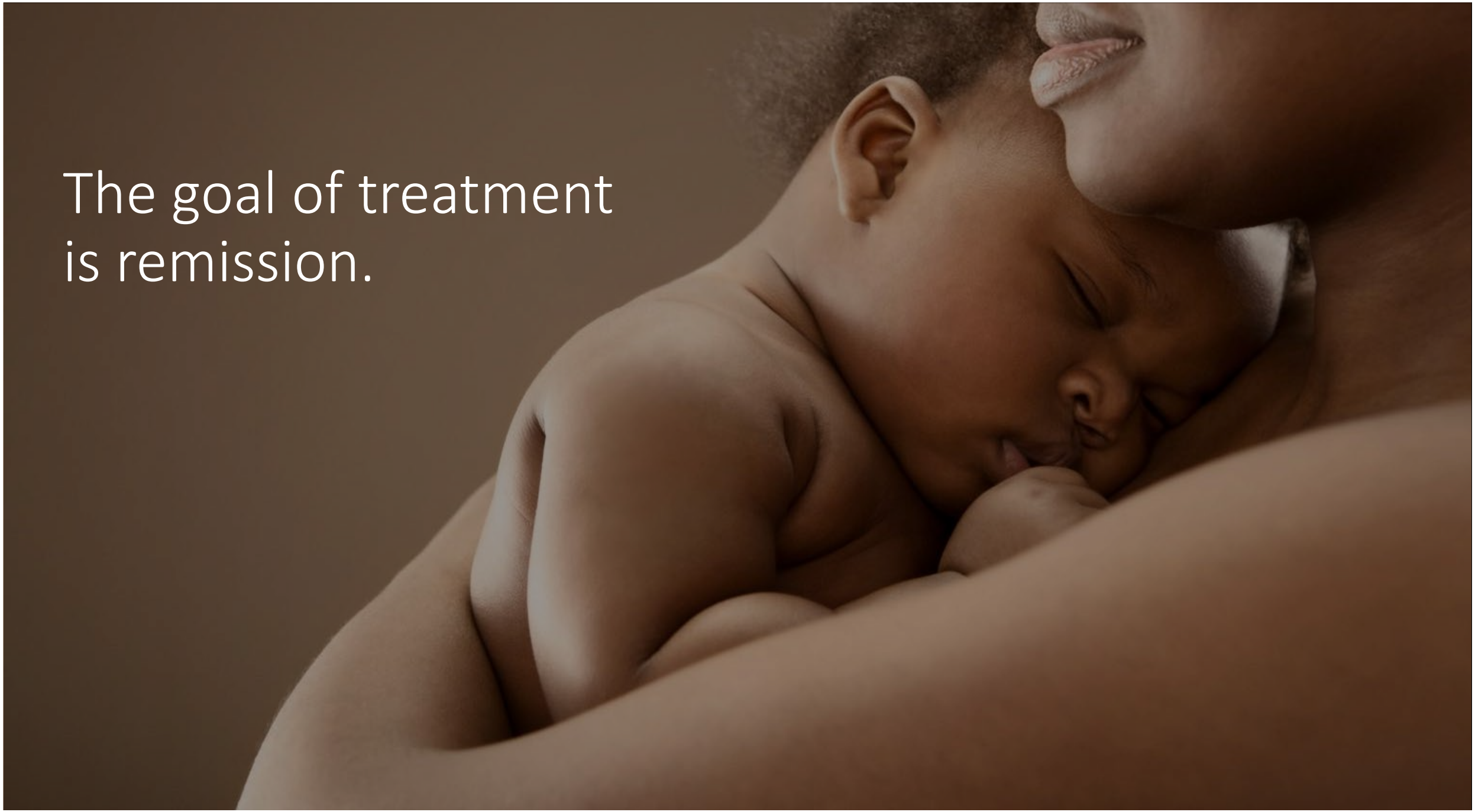
System

Isolated providers

Screening not routine

Siloed care

Regarding treatment –
With rare exceptions, what is best for the birthing person, is best for baby too.


The goal of treatment
is remission.

Risks of un/undertreated psychiatric illness

To the Birthing Person

- Suicide
- Pre-eclampsia
- Dec self-care/prenatal care
- Substance use
- ↑ total med exposures
- Disrupted parental-infant bonding

To the Baby

- Disrupted parental-infant bonding
- ↑ risk of emotional, behavioral, cognitive and psych issues in children
- Preterm birth
- Low birth weight
- Maltreatment, neglect
- Infanticide

Sockol et al. *Clin Psychol Rev* 2013. USPSTF. *JAMA* 2019

Postpartum Depression in Fathers and Partners

Fathers:

- 10% of men experience PPD (JAMA 2010); comorbid anxiety common
- Common symptoms for men include: irritability, agitation, substance use, gambling, isolation, indecisiveness
- Paternal depression – associated with mat depression. (Paulson 2010 JAMA)

LGBTQIA Parents

- Invisibility and vulnerability in this underserved population
- Risk factors: trauma, mental illness, discrimination, financial struggle, lack of support.

Resources for fathers and partners:

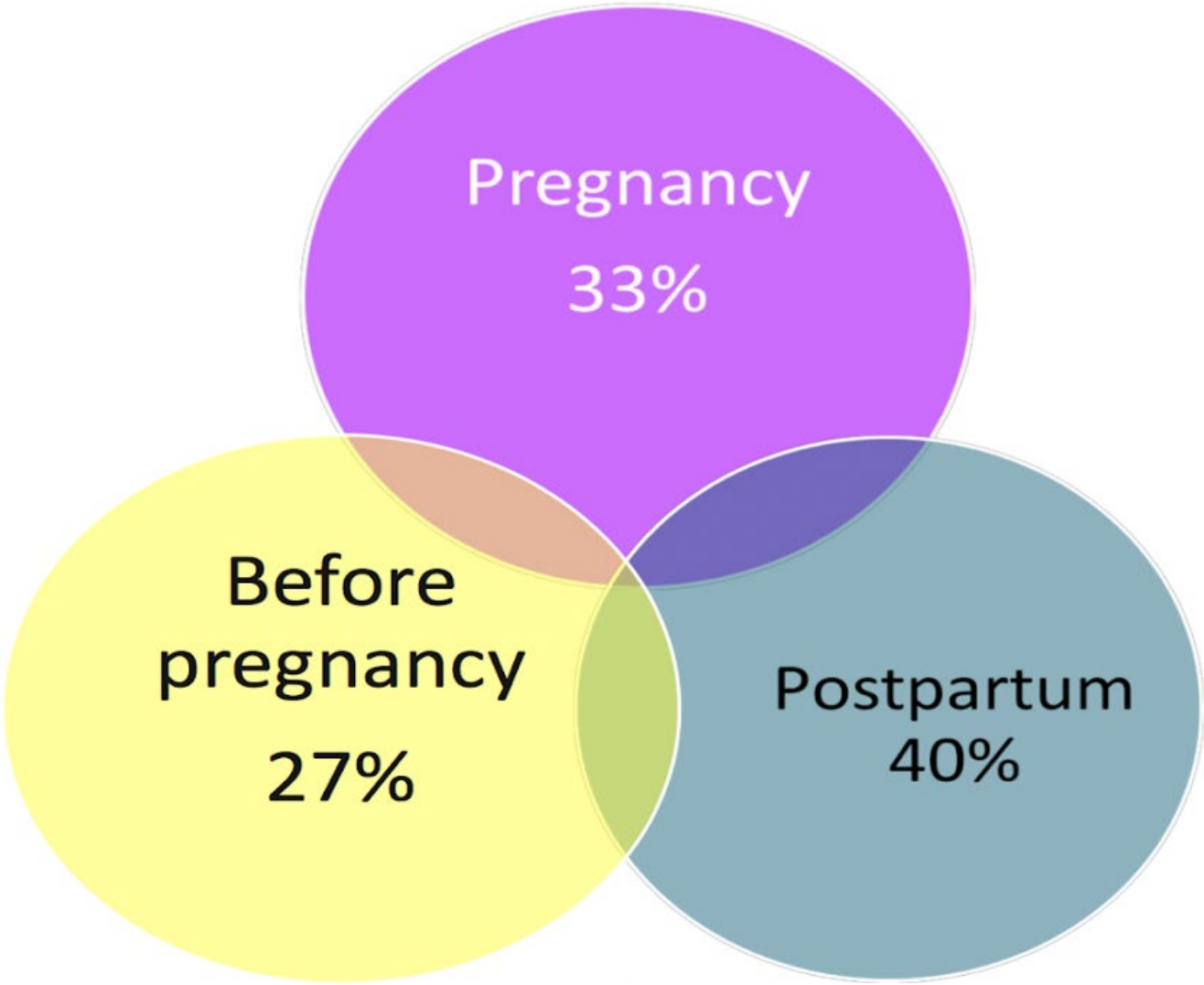
-https://www.postpartum.net/get-help/help-for-dads/

-Faceitfoundation.org

-Support for LGBTQIA+ parents:

https://www.postpartum.net/get-help/queer-parents/

2/3 of perinatal depression begins before birth



The 4 Ss

- Safety
- Support
- Sleep
- Structure

Redleaf Center
For Family Healing

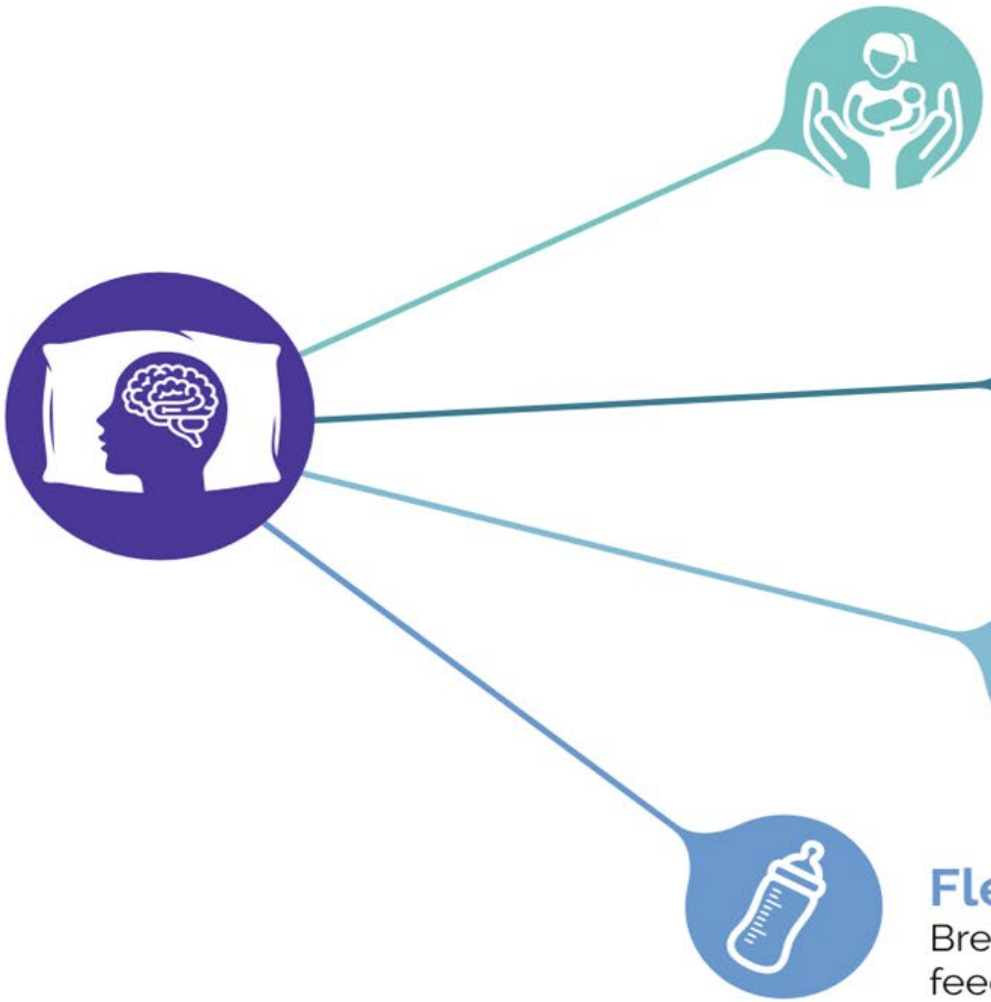
Safety - Assessing Suicidal Risk

Suggests Lower Risk	Suggests Higher Risk
No substance use	Substance Use
No prior attempts or self-harm	History of suicide attempts/self-harm
No plan , No intent	Current plan, intent, suicidal behaviors
Protective Factors – *"What has prevented you from hurting yourself?"*	Lack of protective factors
Able to partner on safety plan	Trauma (historical or current)
	Family Hx of suicide
	Recent discharge from psychiatric hospital
	Hopelessness
	Anxiety/Akathisia

Safety - Assessing Risk to Baby/Children

Suggestive of Obsessions/Anxiety – LOWER risk	**Suggestive of Psychosis – HIGH risk**
Good Insight	Poor insight
Thoughts are intrusive, ego-dystonic	Thoughts are ego-syntonic (often altruistic)
No psychotic symptoms	Evidence of psychosis (delusions, hallucinations, delirium –like presentation)
Thoughts cause anxiety leading to great efforts to avoid acting on them	In and out of touch with reality
	Diagnosis or history of bipolar disorder

Prescribing Sleep



Focus on Self-Care over Self-Sacrifice

Change the message from "A good mother sacrifices for her family" to "Meeting a mother's needs allows her to better care for her family."

Consolidate Sleep

One chunk of 4-5 hours uninterrupted sleep plus another 2-3 hours is better than being woken all night every 2 hours.

Expand the Workforce

Infant night feedings are a job for more than 1 person. Recruit help if possible.

Flex the Breast

Breastfeeding women can pump during the day and have others bottle feed at night. If needed, formula is compatible with breastfeeding.

Leistikow N, et al. Biol Psychiatry. 2022

"Essential . . . Rest is a necessary step in reclaiming our power to resist systemic oppression."
–IBRAM X. KENDI, author of *How to Be an Antiracist* and *Stamped from the Beginning*

REST IS RESISTANCE

A MANIFESTO

TRICIA HERSEY

FOUNDER OF

THE NAP MINISTRY

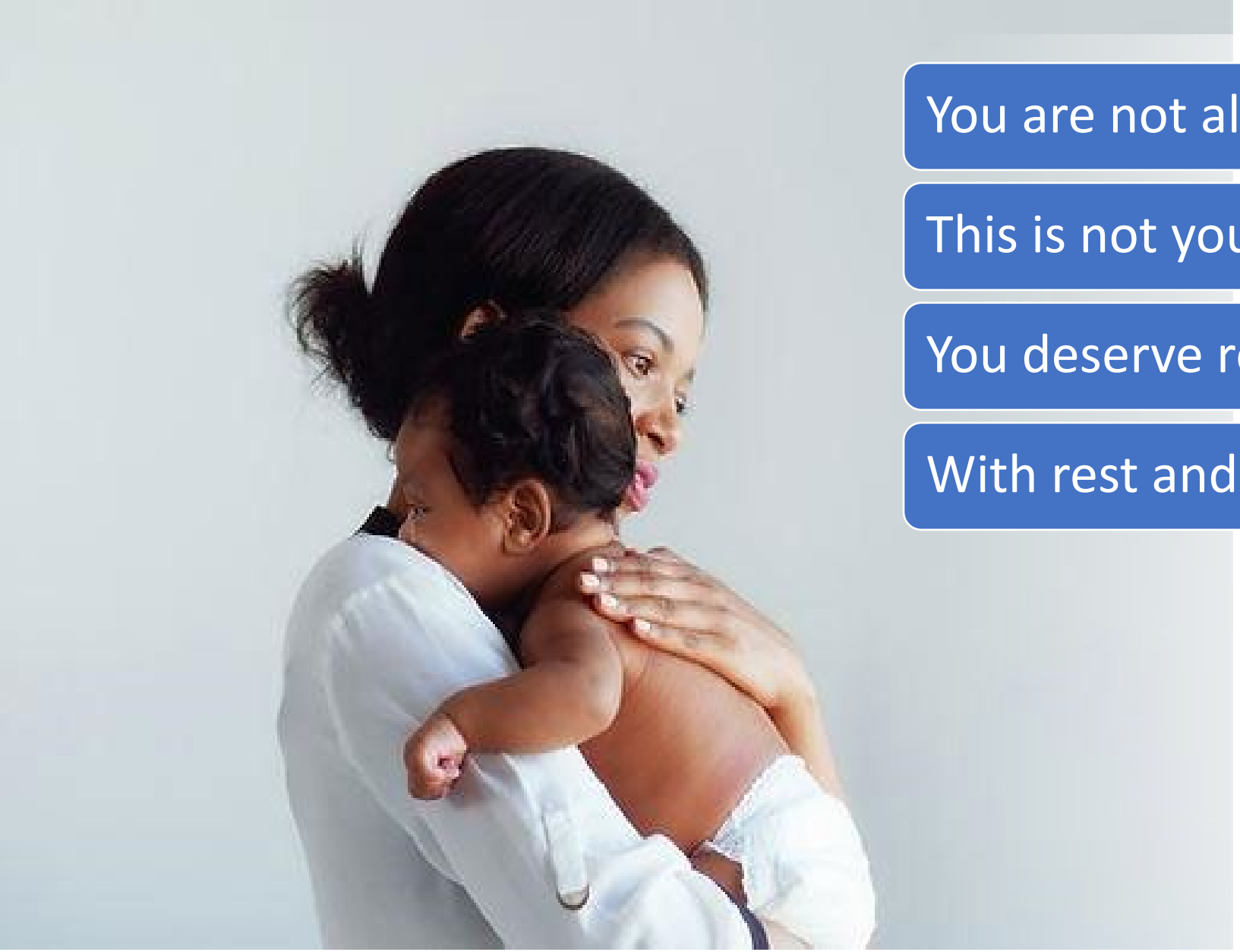
Support

- Identifying and leaning into support
- Deprogramming our thinking that asking for help is weak or I'm a "bad mother" if I can't take care of my baby on my own.

Redleaf Center
For Family Healing

Structure

Creating predictable routines that promote safety, support, meaning, and purpose



You are not alone.

This is not your fault.

You deserve rest and support.

With rest and support, you will feel better.

PSI POSTPARTUM SUPPORT INTERNATIONAL

Get Help

Call the PSI HelpLine:

1-800-944-4773

#1 En Español or #2 English

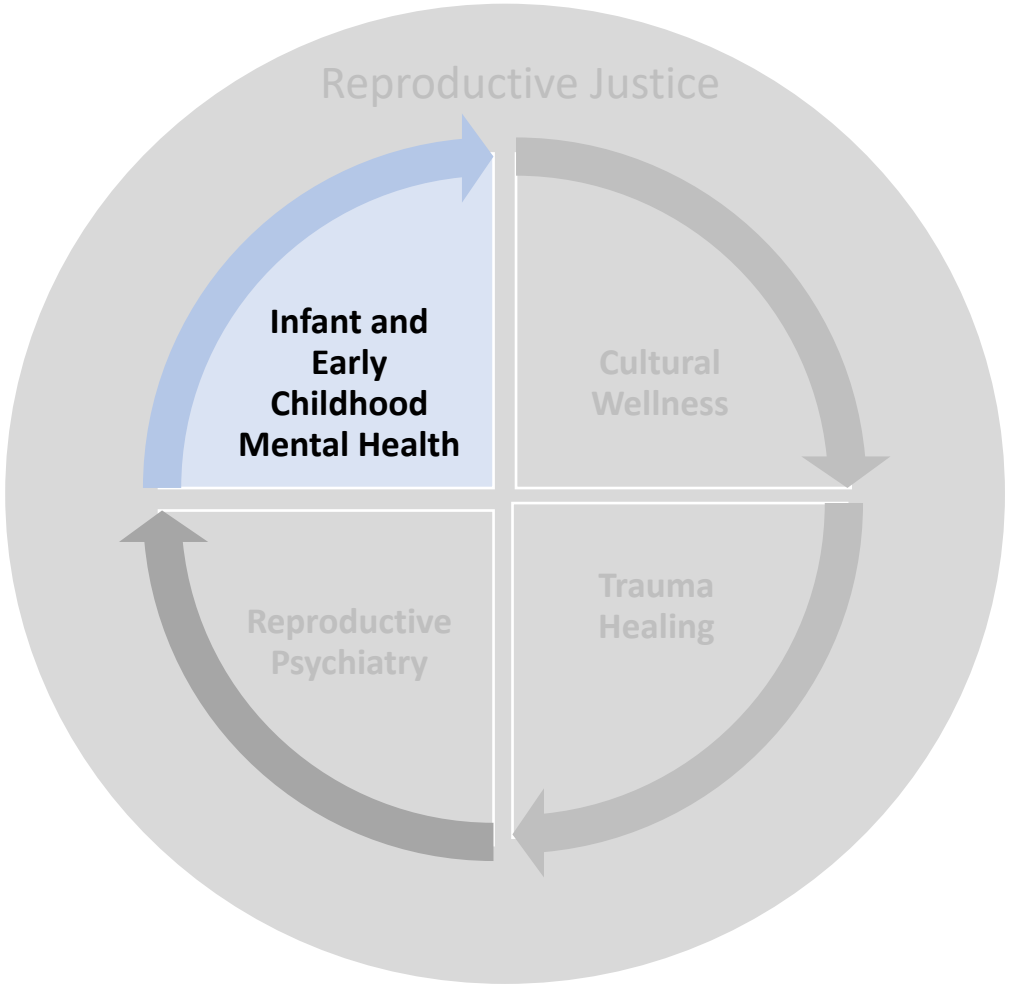
Text "Help" to 800-944-4773 (EN)

Text en Español: 971-203-7773

GET HELP

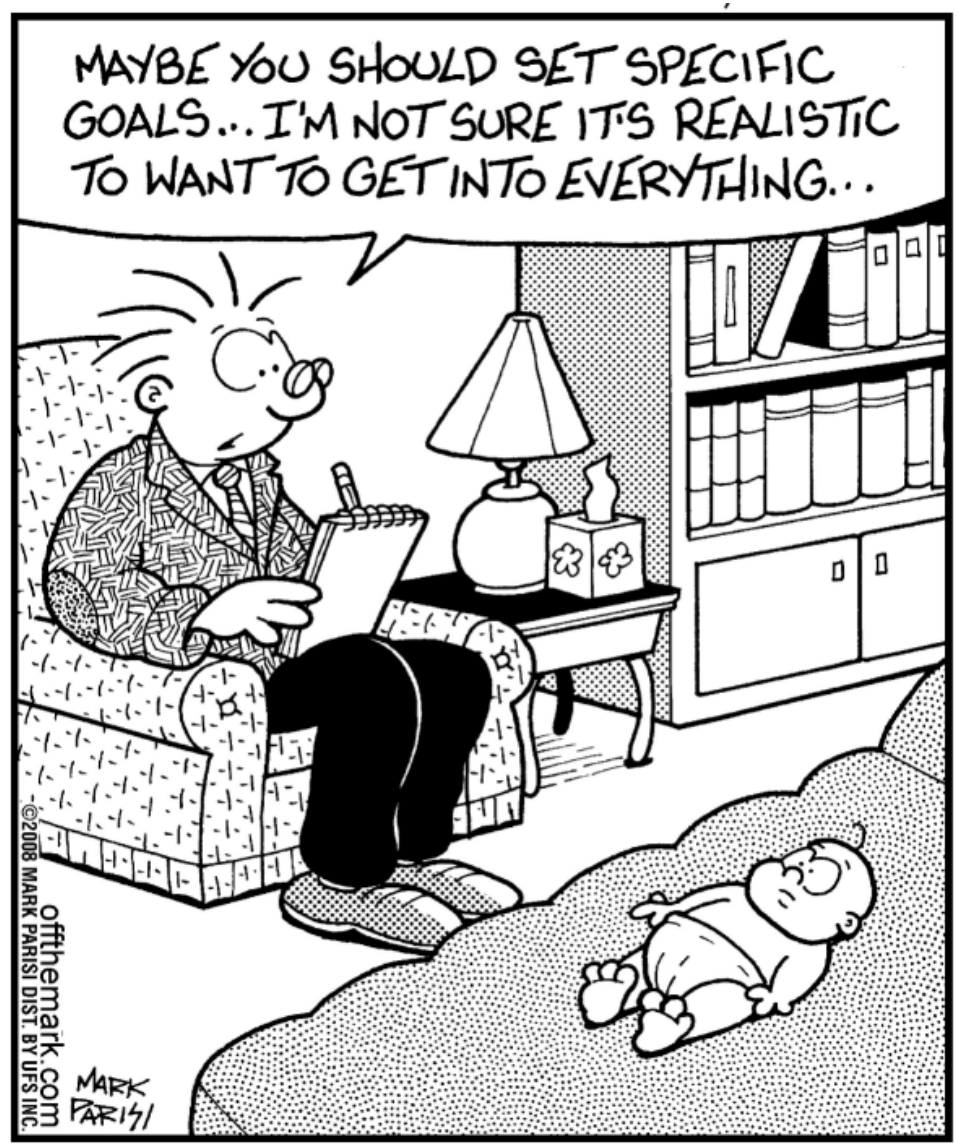
Postpartum Support International ---- postpartum.net

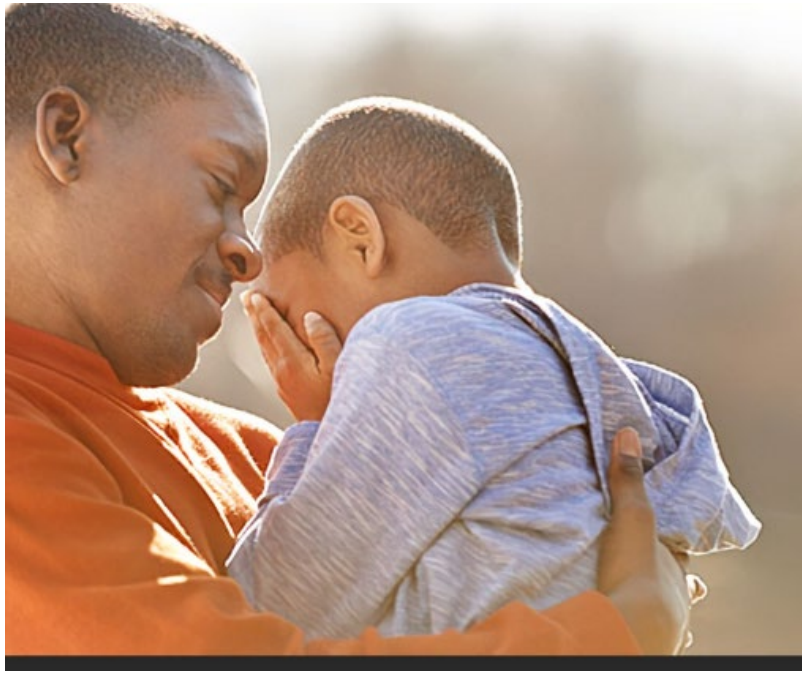
Infant and Early Childhood Mental Health

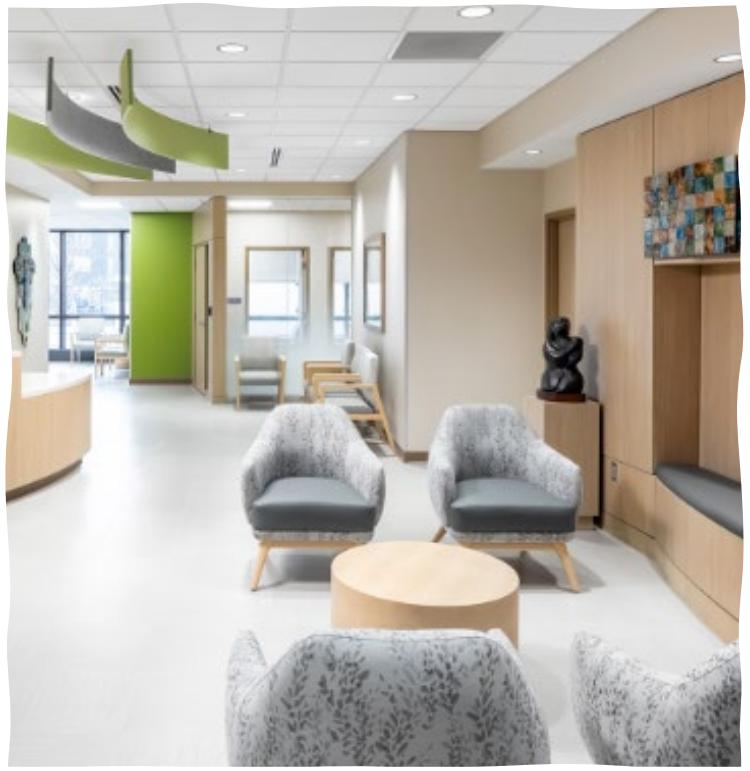

Reproductive Justice
Infant and Early Childhood Mental Health
Cultural Wellness
Trauma Healing
Reproductive Psychiatry

Common Myths

- Children won’t remember what happened to them as babies/young children!
- They will grow out of it!
- Temper tantrums should be ignored!
- Children are resilient!
- Children need to be able to talk to benefit from therapy!







Why is Earlier Better?

- Early experiences shape the architecture of the developing brain – therefore mental well-being is determined by interactions of genes and environment
- Parents and caregivers are under stress
  - System-level stress related to lack of parental leave, lack of affordable childcare, financial stress, racism
- The brain's capacity for change decreases over time
- The course of development can be altered by effective early childhood interventions

(Center on the Developing Child (2007). *The Science of Early Childhood Development* (InBrief). Retrieved from www.developingchild.harvard.edu.)

What is Infant and Early Childhood Mental Health?

- The developing capacity of the child from birth to 5 years of age
  - to form close and secure adult and peer relationships;
  - experience, manage, and express a full range of emotions;
  - and explore the environment and learn—all in the context of family, community, and culture (Cohen & Andujar, 2022).

- Early consistent, predictable, reliable, and nurturing caregiving is generally required for healthy development.

Infant and Early Childhood Mental Health

- **It is essential to treat young children's mental health problems within the context of their families, homes, and communities.** The emotional well-being of young children is directly tied to the functioning of their caregivers and the families in which they live... *Therefore, reducing the stressors affecting children requires addressing the stresses on their families.*

Harvard Center for the Developing Child

Infant and Early Childhood Mental Health As Parent-Child Work

Donald W. Winnicott:

“There is no such thing as an infant' meaning, of course, that wherever one finds an infant one finds maternal care, and without maternal care there would be no infant.”

“The mother gazes at the baby in her arms and the baby gazes at his mother’s face and sees himself therein.”

Prevalence

- 10-23% of mothers in Minnesota experience Postpartum Depression (PRAMS, 2020)
- Approximately 10% of fathers experience postpartum depression (JAMA, 2010)
- 10-22% of children ages 0-5 have diagnosable mental health condition (www.zerotothree.org)

Brief increases in heart rate, mild elevations in stress hormone levels.

Serious, temporary stress responses, buffered by supportive relationships.

Prolonged activation of stress response systems in the absence of protective relationships.

Harvard Center for the Developing Child

3 Realms of ACEs

Adverse childhood and community experiences (ACEs) can occur in the household, the community, or in the environment and cause toxic stress. Left unaddressed, toxic stress from ACEs harms children and families, organizations, systems and communities, and reduces the ability of individuals and entities to respond to stressful events with resiliency. Research has shown that there are many ways to reduce and heal from toxic stress and build healthy, caring communities.

Thanks to **Building Community Resilience Collaborative and Networks** and the **International Transformational Resilience Coalition** for inspiration and guidance.
Please visit **ACEsConnection.com** to learn more about the science of ACEs and join the movement to prevent ACEs, heal trauma and build resilience.

ACEs Connection

Attachment Theory

- All human children need care and connection, and that these needs serve the goal of using a caregiver as a safe haven to derive safety and comfort, as well as a secure base to explore the world.
- Attachment is about proximity-seeking AND exploration
- Function of attachment:
  1. Security
  2. Regulation of affect and arousal
  3. Promoting expression of feelings and communication
  4. Serving as a base for exploration

Attachment

- Attachment system is a fear regulation system supporting child to seek comfort/protection AND explore/learn
- Children develop attachment relationships even if their caregivers are rejecting, inconsistently sensitive, or abusive (Simpson & Belsky, 2016)

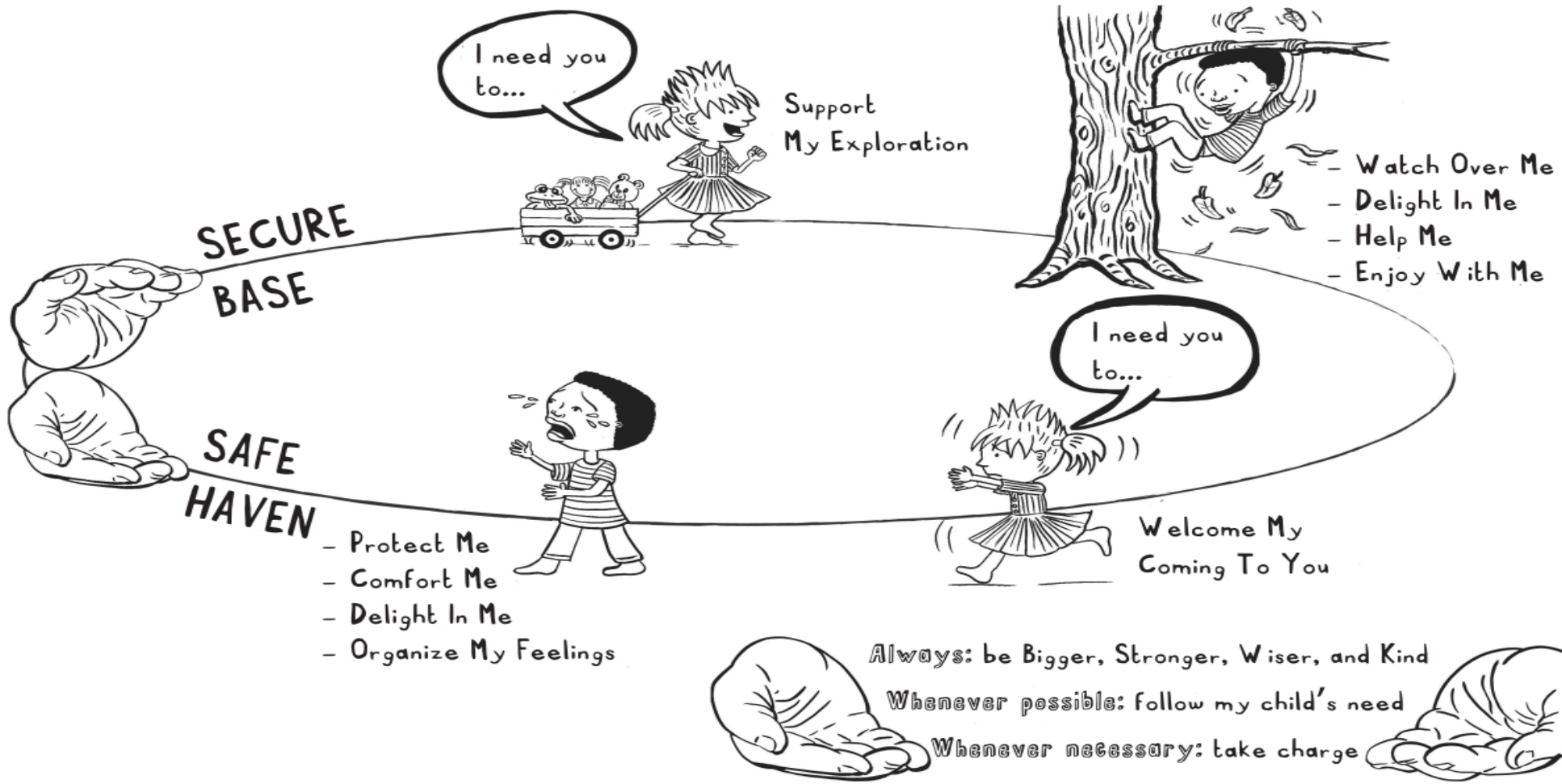
- **Absence of attachment to caregivers is extremely rare** and typically observed only among children who have had insufficient time or experience with a consistent caregiver to develop attachment relationships (Zeanah et al., 2005).

- Attachment Classification can only be determined through laboratory procedure called *Strange Situation* (Secure, Insecure-Resistant, Insecure-Avoidant, Disorganized)

https://www.tandfonline.com/doi/full/10.1080/14616734.2020.1840762

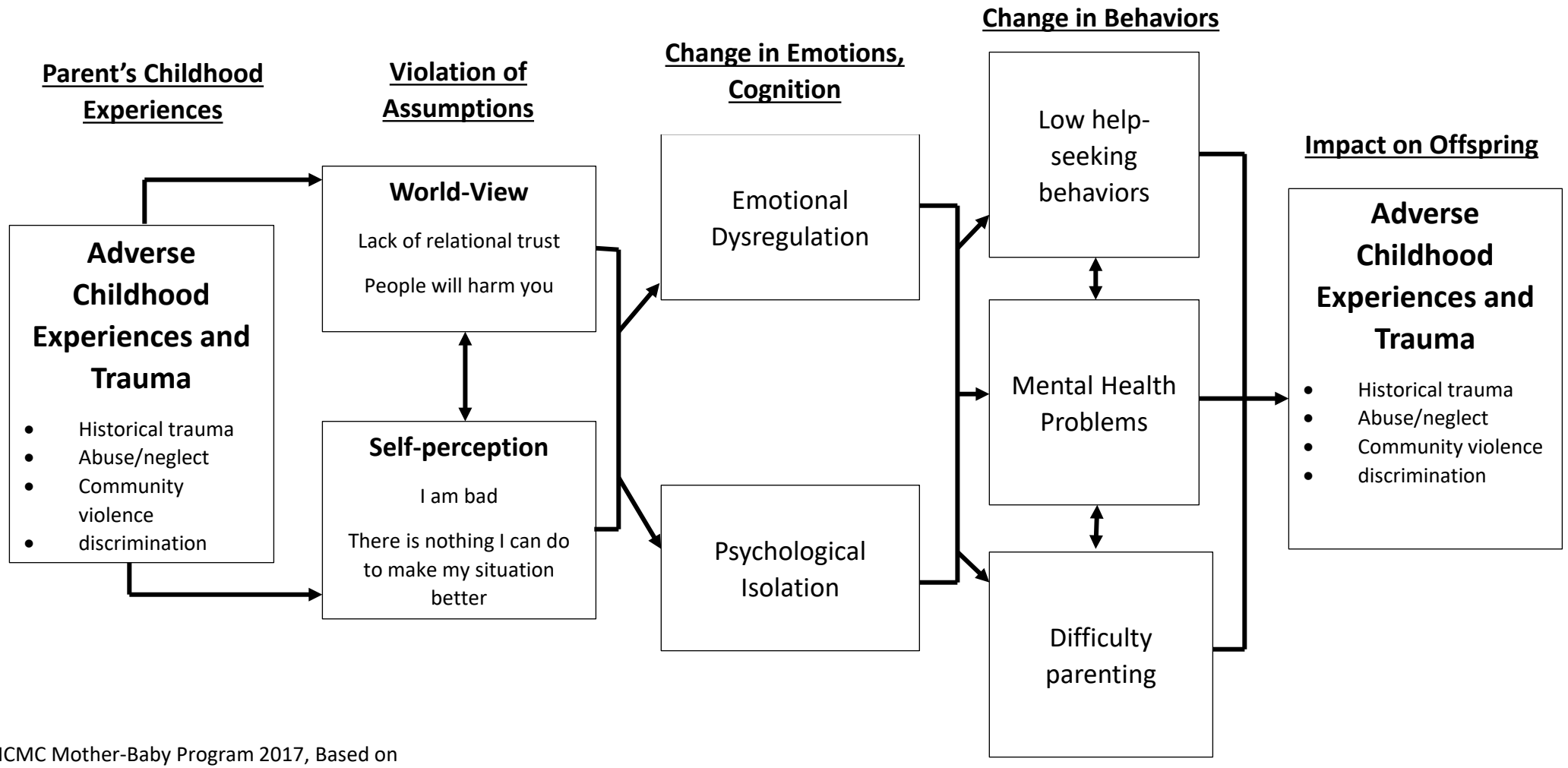
Circle of Security®

Parent Attending To The Child's Needs



What makes it difficult to provide these things for our children?

Intergenerational Transmission of Adverse Childhood Experiences



HCMC Mother-Baby Program 2017, Based on Conceptual Framework on trauma and help-seeking, Muzik 2017. Based on Edna Foa, Mardi Horowitz, John Bowlby & Liang, Goodman, Tummala-Narra, & Weintraub, 2005.

Avoidant: overregulation, minimizing

Resistant: underregulation, maximizing

Disorganzed: collapse of regulation

Ghosts in the Nursery

- Ghosts in the Nursery: Refers to the relationship between a parent's early, often negative experience of the way they were raised and their own parenting style.

"But how shall we explain the group of families who seem to be possessed by their ghosts? The intruders from the past have taken up residence in the nursery, claiming tradition and rights of ownership. They have been present…for two or more generations…The baby in these families is burdened by the oppressive past of his parents from the moment he enters the world…" (Fraiberg, 1975)

Angels in the Nursery

Angels in the Nursery:

Refers to positive early experiences between a caregiver and child that result in the child developing strong feelings of security and self-confidence. When the child becomes a parents, they can draw on these feelings in order to interrupt transmission of trauma.

(Lieberman et al, 2005)

Ghosts and Angels in the Nursery

Simms Mann Institute

A note about…

Temperament

"From the moment of birth relationships shape biology and so measures of temperament are always to an extent measures of temperament"

(A. Sroufe)

Resiliency

- Children are not just "resilient" in the face of adversity
- The amount of support they have to "buffer" adversity determines their capacity for healthy development

(Harvard Center for the Developing Child)

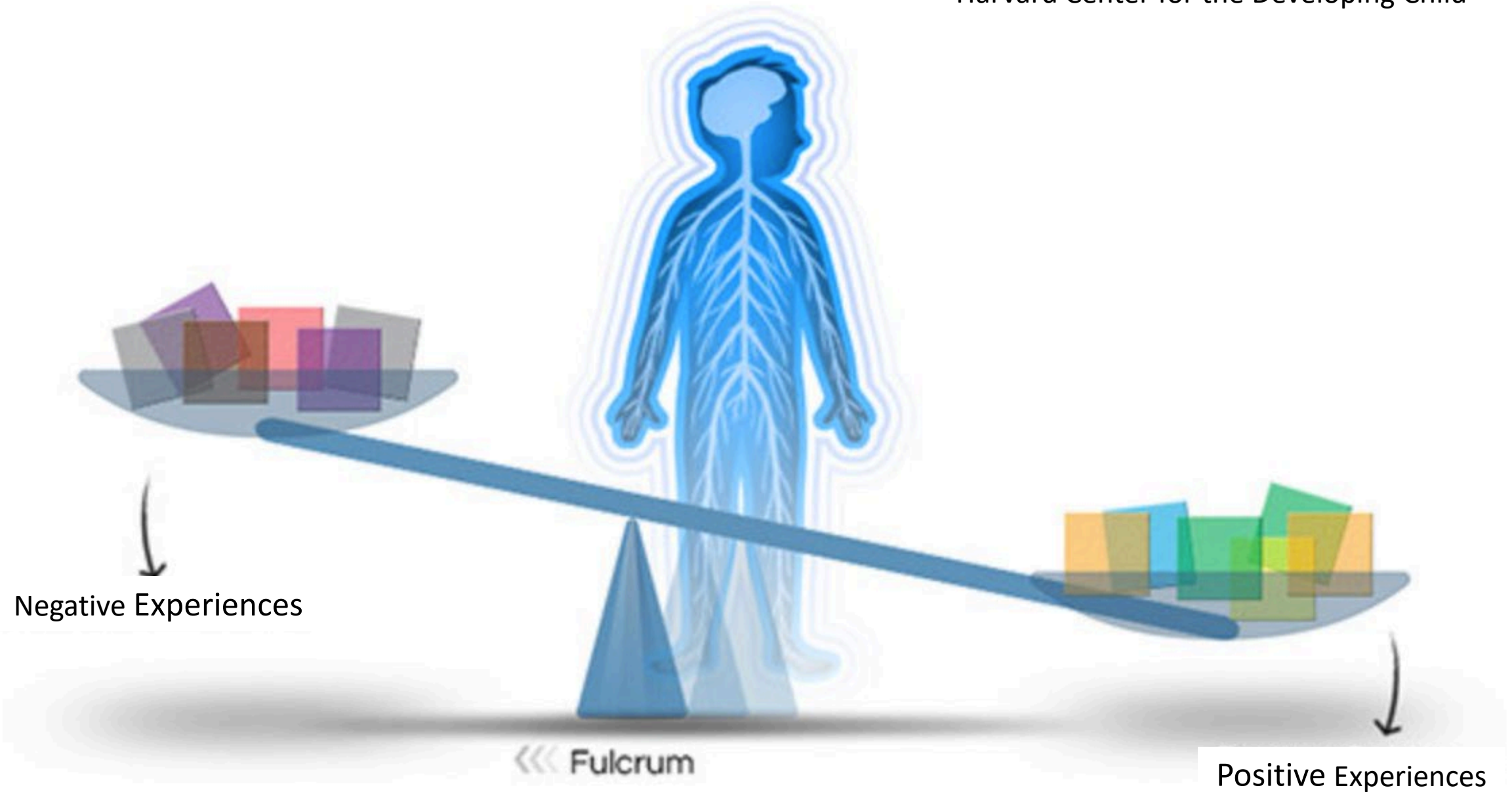
How do we support positive outcomes for families with very young children?

Research has identified a common set of factors that predispose children to positive outcomes in the face of significant adversity.

1. Facilitating supportive adult-child relationships;
2. Building a sense of self-efficacy and perceived control;
3. Providing opportunities to strengthen adaptive skills and self-regulatory capacities; and
4. Mobilizing sources of faith, hope, and cultural traditions.

Harvard Center for the Developing Child

Harvard Center for the Developing Child



When to Refer

- Clinically significant symptoms are distinguished from developmentally appropriate behaviors by
  - their severity
  - the distress they cause the family and child
  - the adverse impact they have on the young child's family functioning and child's development (DC 0-5)

When to Refer

- Parent/caregivers are expressing distress about child
- Satisfying interactions with child are not common/difficult
- Child's development is raising concern for provider/caregiver: social-emotional, behavioral, expressions of distress/stress
- Difficulties persist after adjustment period
- Consistent issues with sleep/feeding/toileting that are outside of developmental/cultural expectations

Parents Words…

"My baby hates me. She won't stop crying."

"My daughter's anxiety is a driving factor in how my day goes."

"She falls out too much when she doesn't get her way."

"My toddler just wants to make me mad."

"I'm concerned about what he has witnessed at his mom's house"

"He is so disrespectful and doesn't seem to care when I scold him."

"Everyone tells me she is too young to be assessed for autism, but I am worried."

"We were in a bad car accident and now my son is refusing to go to childcare."

"I just want help so that I don't harm my kids the way that my parents did to me."

Assessment

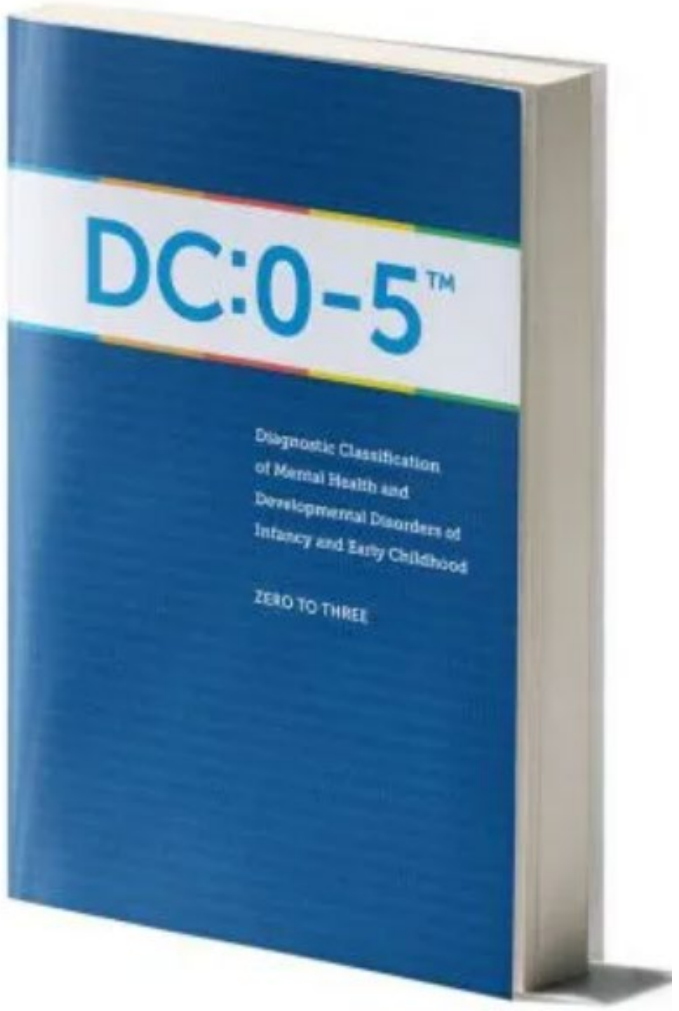
Grounding Questions

- What is typical development and how has it gotten off course?
- Can difficulties/developmental functioning be understood within cultural context?
- How is the relationship working for the child and parent/caregiver(s)?
  - To regulate fear
  - Preserve closeness/intimacy
  - Support exploration

- Balancing act:
  - Avoid pathologizing children, consideration of normal variations of typical development
  - Identify children with a clinically impairing mental health disorder to increase chance of access to early intervention

DC: 0-5

- Axis 1: Clinical Disorder
- Axis 2: Relational Context
- Axis 3: Physical Health Conditions and Considerations
- Axis 4: Psychosocial Stressors
- Axis 5: Developmental Competence



Diagnosis

- Significant mental health problems can and do occur in infants and young children
- Symptoms often manifest differently in very young children than in older children and adults
- Psychological testing by psychologist required for neurodevelopmental disorders
- Oppositional Defiant Disorder is not an allowable diagnosis in 0-5 children in Minnesota
- Much symptom overlap – ADHD should be diagnosed with extreme caution in young children

Assessment with Young Children

- We diagnose symptoms, not children – expectation that with intervention, symptoms will improve.
- Reassessment important at all stages, but especially during early childhood
- Impairment required for diagnosis: distressing for child, impacts family and child's development, interferes with relationships

Assessment Tools

Clinical Interview

- Therapist and caregiver(s)

Observation

- Therapist observation in childcare setting
- Parent-child play observation in clinic/home

Parent/Teacher Report

- Child Behavior CheckList (CBCL)
- Ages and Stages (ASQ)
- Parenting Stress Index (PSI)
- Early Childhood Service Intensity Instrument (ECSII)

Assessment Visits

- Session one: with parent/caregiver(s) alone
- Session two: parent-child observation
- Session three: Feedback session with parent/caregiver(s)
- Option: observe child in childcare setting

Intervention

“Parenting patterns rooted in one’s own history and experiences are not easily altered by information alone; one must feel seen to see, feel understood to understand, feel cared for to care.”

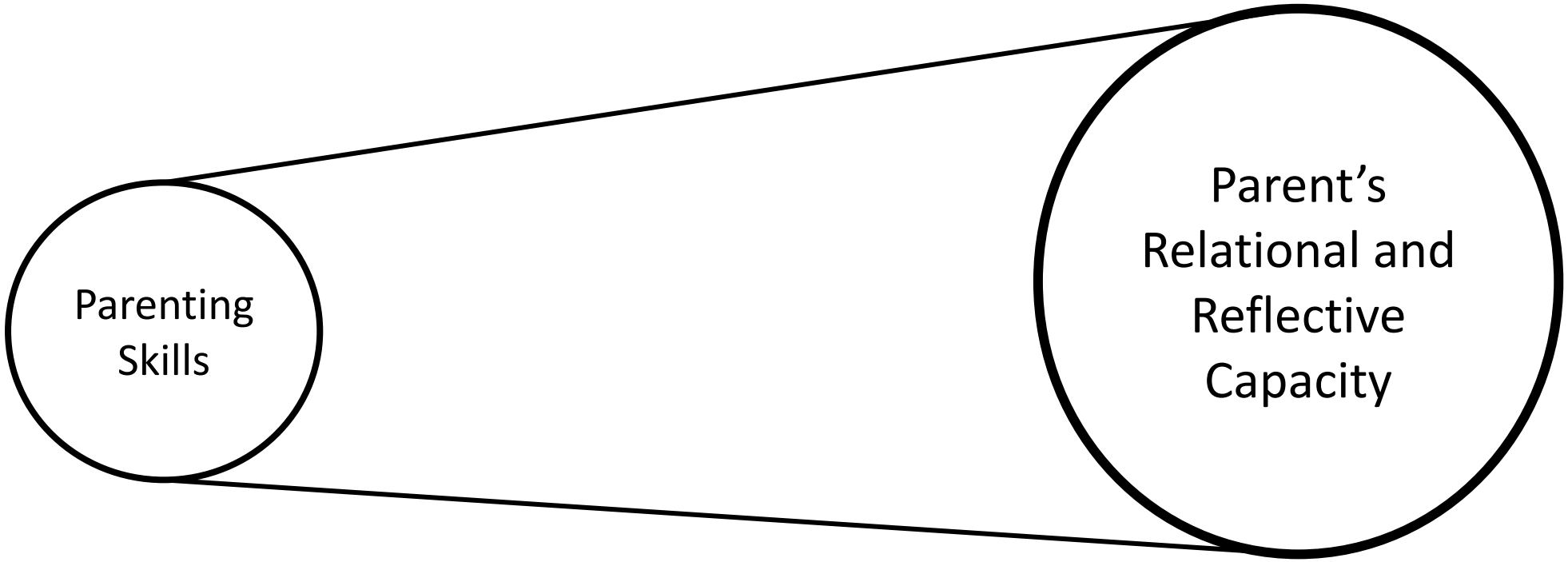
(Weatherston & Ribaudo, 2020)

When there is affect in the room “the first affect to regulate is your own.”

(Lieberman & Van Horn, 2005))

“If a problem can’t be solved, enlarge it.”

Dwight D. Eisenhower


Parenting Skills
Parent's Relational and Reflective Capacity

Dyadic IECMH Interventions

- **Attachment and Bio-Behavioral Catch-Up (ABC)**
  - ABC newborn (begins during pregnancy)
  - ABC Infant (6 mos to 2 years)
  - ABC Toddler (2 yrs to 4yrs)

- **Child Parent Psychotherapy (CPP)**
  - For parents and children 0-6 yrs

- **Parent-Child Interaction Therapy (PCIT)**
  - For parents and children 2-7 yrs

Parent-Only IECMH Interventions

- **Circle of Security-Parenting**
  - For parents only, especially parents of children 0-6 years old
  - Reflection/psychoeducation

- **Supportive Parenting for Anxious Childhood Emotions (SPACE)**
  - Treats childhood anxiety

CPP

- CPP is an intervention model for children aged 0-6 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including posttraumatic stress disorder.
- The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories.
- Therapeutic sessions include the child and parent or primary caregiver.
- The primary goal of CPP is to support and strengthen the relationship between a child and his or her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning. Treatment also focuses on contextual factors that may affect the caregiver-child relationship. (NCTSN)

PCIT

- PCIT is a specialized, evidence-based treatment program designed for caregivers and their young children (2 to 7 years of age) who are experiencing behavioral and/or emotional difficulties.
- 12-20 sessions with “bug in the ear” coaching

ABC

- ABC is an evidence-based intervention that partners with parents to support young children exposed to early adversity.
- Perinatal, Infant and Early Childhood versions
- Delivered over 10 sessions using video review

Family Example - Referral

- Young Latina mother of toddler ages 2 years 1 month when referred
- Described concern about son’s temper tantrums to pediatrician
- Multiple sources told her to ignore the temper tantrums
- Frustrated because ignoring didn’t seem to help and neither did responding to him

ABC-Early Childhood Targets

- Providing nurturance when child is sad, scared, seeking proximity
- Following the lead
- Delight
- Avoiding lectures and power struggles
- Calming when child is frustrated, mad, dysregulated

Lunch Break
12:15pm-1:15pm

Group Experience: Mindful Movement

The Mother-Baby Clinical Model

Mother-Baby Program

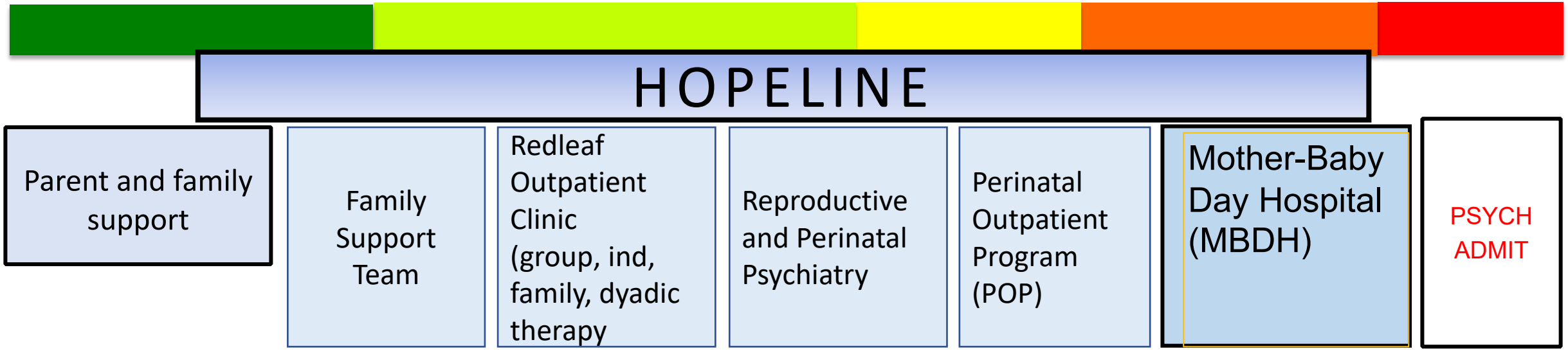
*To save lives and support families by strengthening the emotional health **and** parenting capacity of pregnant women and mothers*

Multi-generational care:
Downstream intervention for mom and
Upstream intervention for baby

HennepinHealthcare

Redleaf Center
For Family Healing

Mental healthcare for families expecting a baby or parenting young children



HennepinHealthcare

Mother-Baby
DAY HOSPITAL

- Partial Hosp Program for pregnant women and mothers of children 0-5 years old
- The first and only in Minnesota, 4th in the U.S.
- ***For women with moderate to severe mood, anxiety, or trauma-related disorders***
- 20 hours per week for 4 weeks
- Babies 12 months and younger attend with their mom

Redleaf Center
For Family Healing

Reproductive Status (n=272)

Pregnant	12%
0-12 months PP	78%
More than one year PP	10%

Demographics

Married/Partnered	70%
Public Insurance	44%
College or beyond	50%
Lack of social support	88%
First-time mom	51%
Food insecurity	40%
Housing instability	40%

Diagnosis

PTSD	20%
MDD	58%
Bipolar I or II	25%
Anxiety	46%

Mother-Baby Day Hospital:
where the streams meet --
opportunities for generational healing

Adverse Childhood Experiences

At least 4 ACEs = 57%

(vs 15% in ACEs study)

Kim, Kuendig, Erickson. 2020

The Redleaf Way

Redleaf Center
For Family Healing

Jasmine

https://drive.google.com/file/d/1pxq8n0NAbyxHVcWp6Y4AXb6PU-AQFSMz/view

In Their Own Words…
Frightened/Frightening Beginnings

The Redleaf Clinical Mindset

- Antepartum and postpartum distress is both an individual and relational crisis

- We see the patient; the patient and baby; the patient's past and present experiences; social support systems; the relationship between clinician and patient; as well as the cultural and racial context in which the patient and baby live.

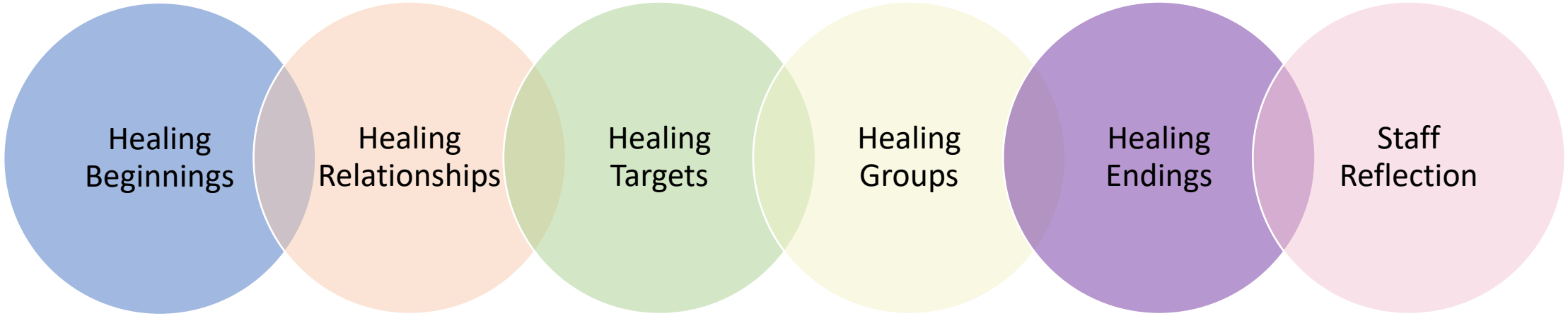
- Our mindset recognizes that illness can impact parenting in difficult ways but also that parenting, when supported, can impact illness in positive ways.

Theory of Change

Mothers with acute psychiatric distress during pregnancy or while parenting young children–especially those most impacted by trauma and adversity–benefit from participating in safe, healing relationships that support regulation and foster exploration of their past and present experiences.

Through these healing opportunities, they may practice new ways of being in relationship with themselves, their baby, and others in a way that leads to more stable, flexible, coherent, and compassionate experiences of themselves and their parenting.

Redleaf Model Components



Flynn J, Kim HM, Gearity A, & Erickson N

Staff Reflection

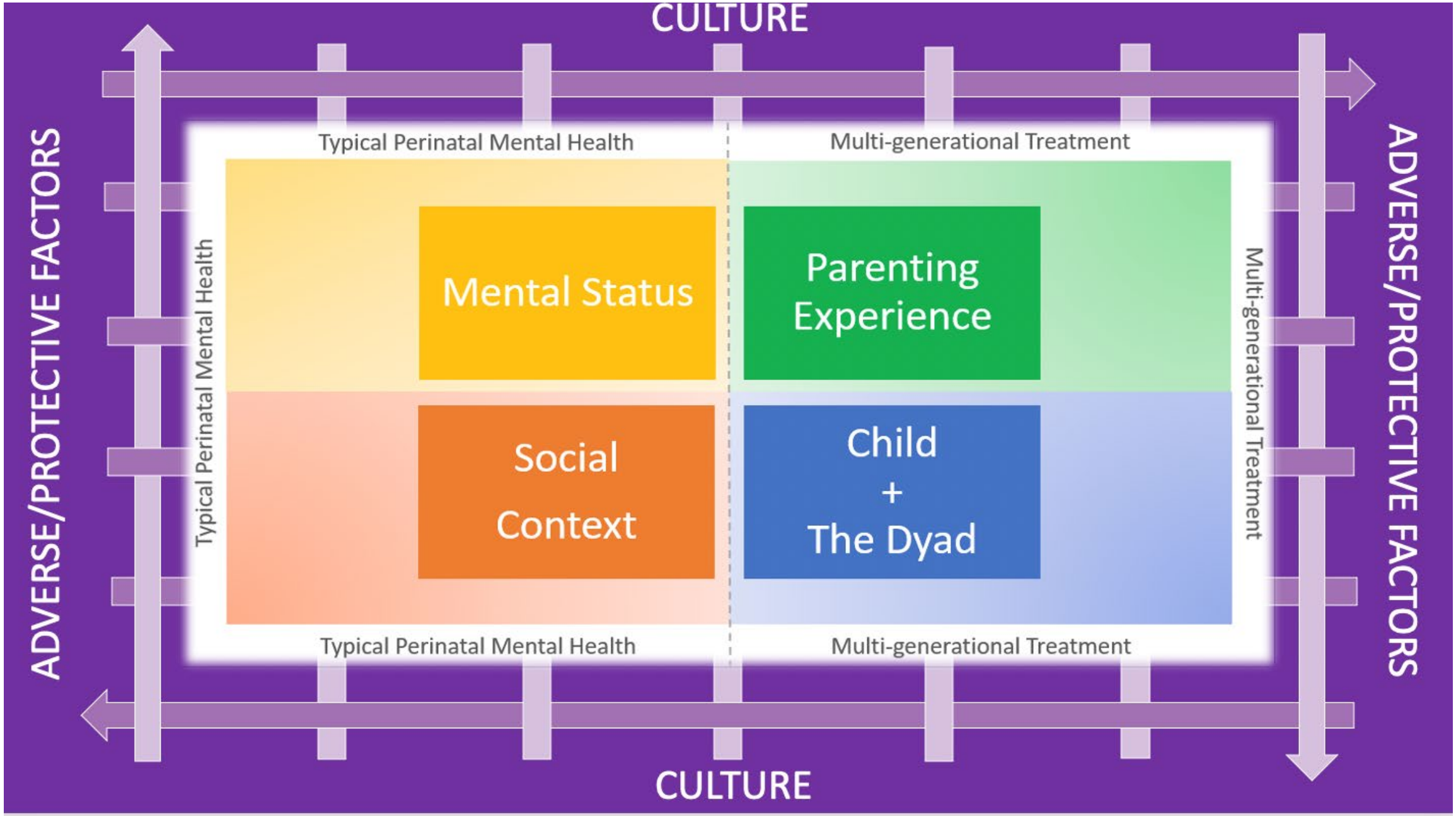
The clinician must "settle into the commitment to listen, to be wholly present, engaged, and attuned to the patient."

The clinician's challenge is "to wade into the life of someone she has never met before."

The clinician's therapeutic posture is "I'm taking you seriously and I'm willing to hear anything you have to say to me. With me you can speak your unspeakable thoughts." (Cardone, 2006)

Clinicians are "*story catchers*"--able to skillfully listen and reflect back the stories shared by patients. At the same time, we are diagnosticians. Going back and forth between these two ways of listening--as both a story catcher and a diagnostician to help answer the questions:

What is happening to me? And Can you help me?


CULTURE
ADVERSE/PROTECTIVE FACTORS
Typical Perinatal Mental Health
Multi-generational Treatment
Typical Perinatal Mental Health
Mental Status
Parenting Experience
Social Context
Child + The Dyad
Multi-generational Treatment
Typical Perinatal Mental Health
Multi-generational Treatment
ADVERSE/PROTECTIVE FACTORS
CULTURE

Healing Relationships

Healing happens in relationships…

- We consider relationships between the mother and staff, mothers with other mothers, mother and herself, and mother and baby;

- Relationships function as both *a safe haven* for mothers (providing safety, nurturance, and co-regulation) and *a secure base* (allowing mothers to explore, reflect, and build self-awareness).

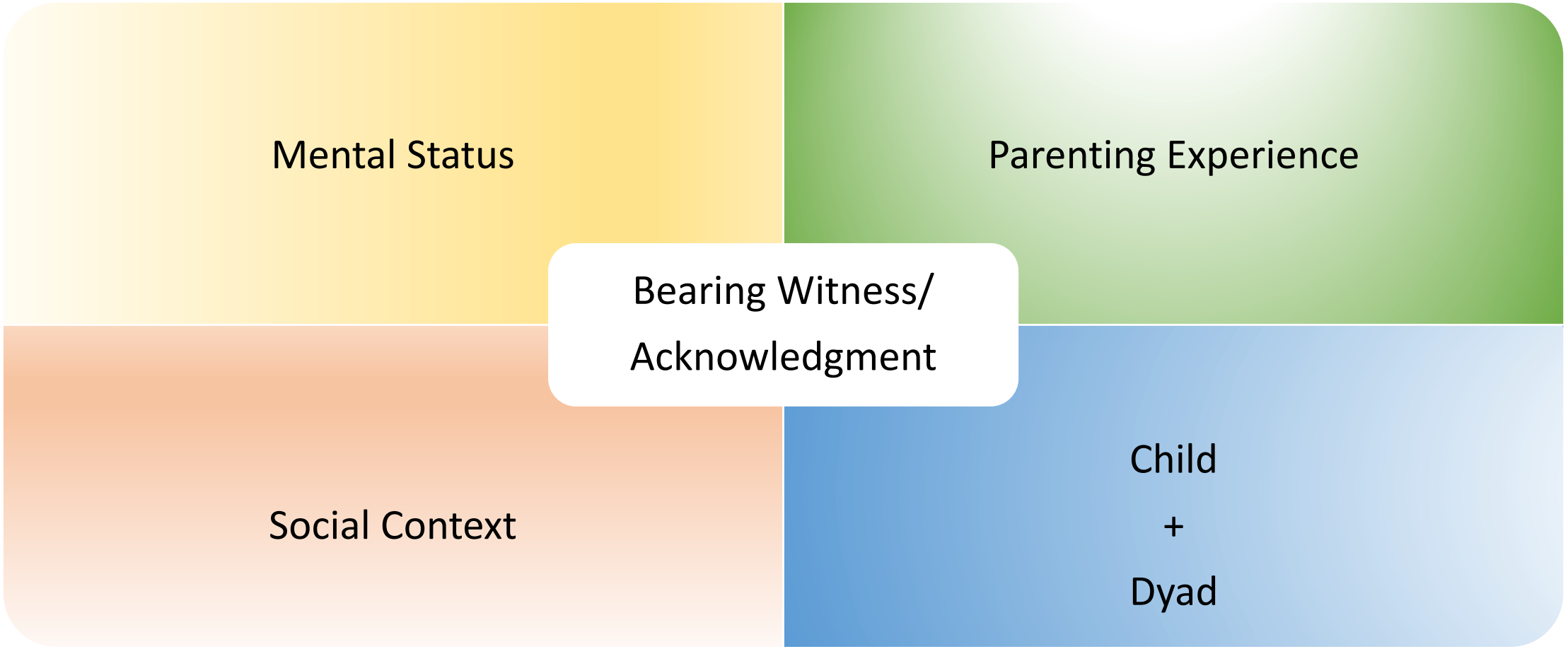
Healing Relationships

“For those who are the most directly victimized, the complicity and silence of bystanders – friends, relatives, and neighbors…feel like a profound betrayal, for this is what isolates them and abandons them to their fates.” (Herman, 2023)

Passive Bystander

Bearing Witness

Acknowledgment


Mental Status
Parenting Experience
Bearing Witness/
Acknowledgment
Social Context
Child
+
Dyad

Healing Groups

“If traumatic disorders are afflictions of the powerless, then empowerment must be a central principle of recovery. If trauma shames and isolates, then recovery must take place in community.”

(Herman, 2023)

Healing Groups

- Provide safety, support, and structure
- Feel less alone
- Bearing witness….public acknowledgment
- Experience
  - Giving and receiving support
  - relating to others who may be similar and different...
  - Rupture and repair
- Reflection and support are modeled…
- Feel hope

Gathering Group

Psychotherapy Group

Shared Meal

Movement Group

Circle of Security-Parenting Group

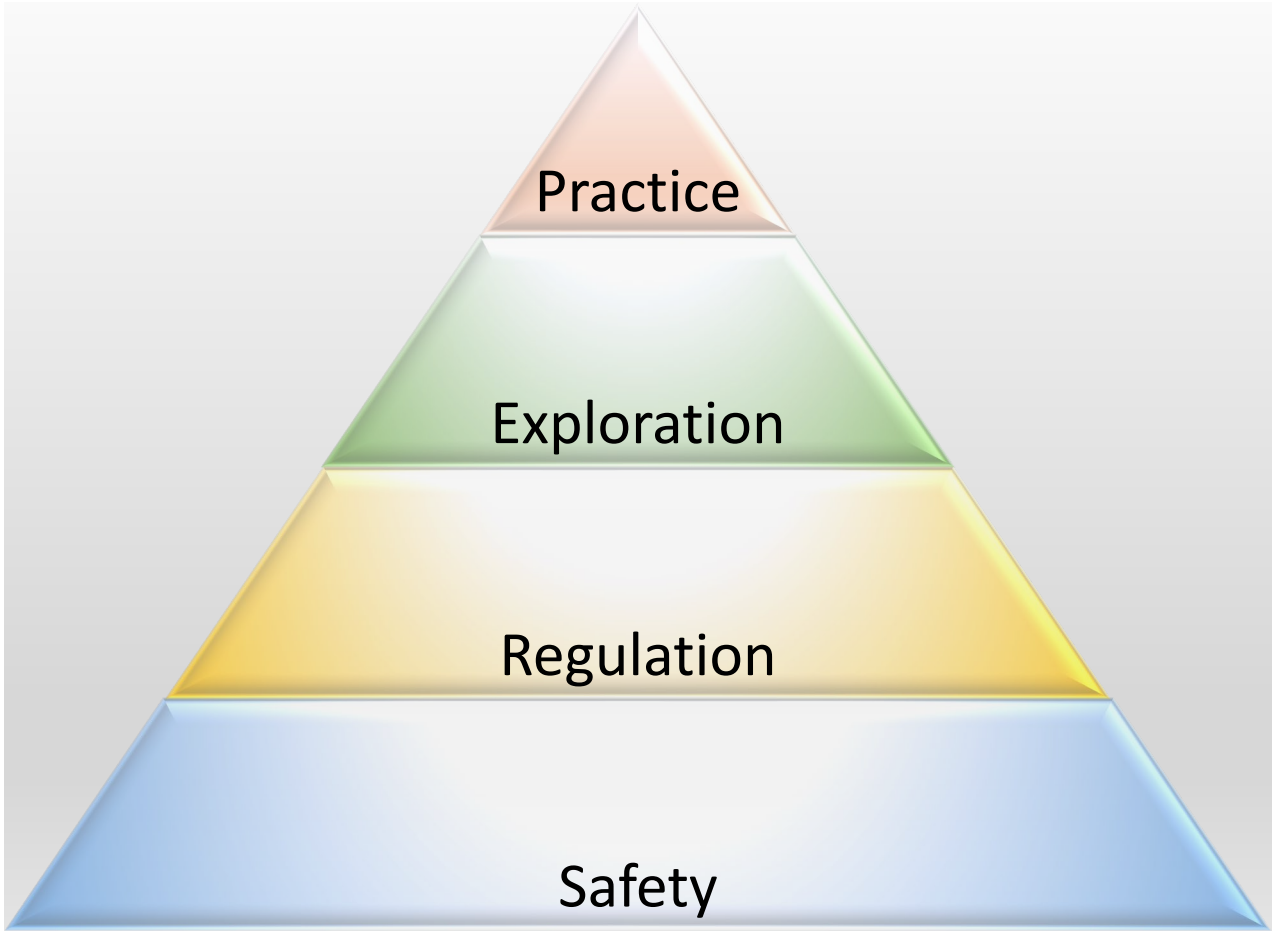
Psychoeducation Group

Closing Group

Healing Groups

Healing Targets

S-REP




How do you support safety?

Safety

- Highest priority is to support the client's felt sense of safety
- TIC principles – voice/choice, empowerment, collaboration, transparency
- Structure as a means towards flexibility
- Delight - Notice anything that is going well and/or their efforts to take care of baby and themselves
- Return to safety as many times as needed

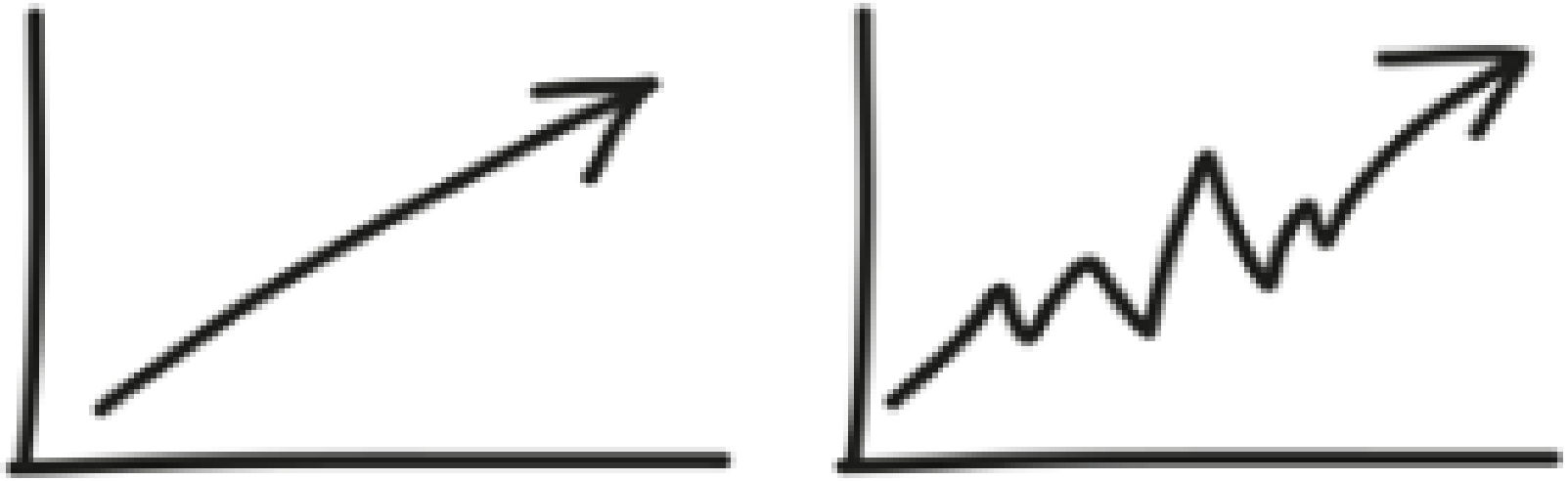
Regulation

- Mental illness and mental distress are often expressed with physical and emotional dysregulation;
- Regulation is both a body and a mind experience;
- In addition, psychoeducation is helpful to identify skills that support better regulatory balance;
- Parallel process – self, baby, parent, group

Exploration

- Their own and child's internal experiences
- Their histories and how they get activated in the present
- The very real, present day threats to safety and regulation
- A different future
- Identity as individual vs. parent
- Justice as healing

- Going out/coming in as part of daily practice
- Opportunities to practice caring for baby with support
- New ways of relating to self, baby, other



- Ending can activate feelings of loss, abandonment, fear
- Practice/going out
- Returning if necessary
- Graduation rituals

What do you want new patients to know?

Healing Endings

You are worthy
Help is on the way – within you and all around you!
It is a long journey…this is the start
You are enough
You are so good - You have always been good
You're in the right place! Ask for all the help and keep asking!
There's no way to be a perfect mom, but a million ways to be a great one
Your feelings are valid
You deserve support
You deserve to take up space
You are not alone

connection
working
feedback
getting
always
better
skills
staff
going
needed
family
made
helpful
meeting
team
security
felt
good
people
hard
supportive
cos
dr
nice
sharing
moms
love
help
similar
open
women
health
knowledge
daily
feelings
son
seeing
needs
situation
feeling
different
issues
setting
share
much
life
hear
helped
great
baby
program
loved
heard
lunches
amazing
also
therapy
really
learned
coping
validated
therapists
bonding
mothers
individual
psychotherapy
place
judged
caring
members
gave
mom
therapist
support
structure
motherhood
food
understand
enjoyed
kind
get
see
less
knowledgable
check
group
approach
well
advice
work
never
circle
every
skilled
emotions
lunch
learn
talk
day
know
feel
everything
learning
change
hearing
able
mental
way
experiences
thing
struggles
understanding
safe
understood
excellent
bringing
wonderful
liked
others
alone
like
education
access
judgement
respectful
community
parenting
talking
kim
time
babies
thoughts
welcoming

“We learn over time that everything we think we know is a hypothesis; that we have ideas, but that we don’t have truth….”

(Dr. Jeree Pawl, 1995)

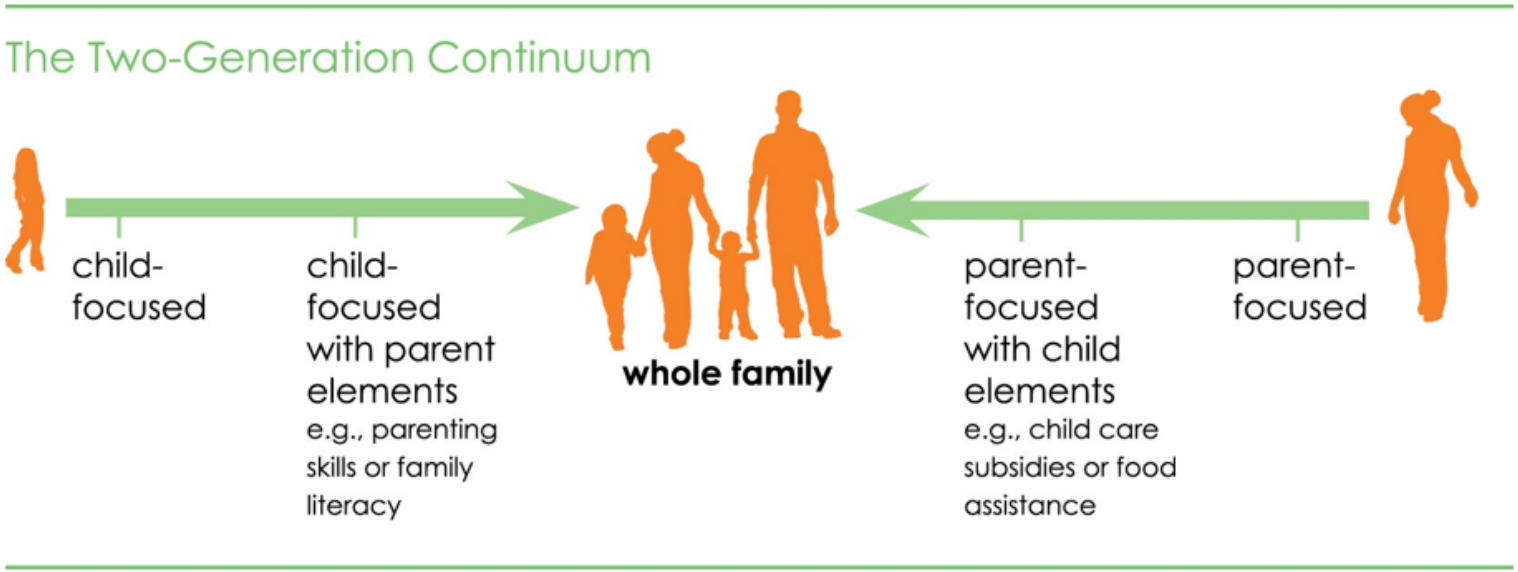
Small Group Activity: Case Formulation

Case Formulation

”The initial assessment is not purely a time for gathering information toward a case formulation. Starting with the first encounter, clinicians can make important therapeutic alliances and establish themselves as collaborative partners engaged from the very beginning in an effort to improve the situation as promptly as possible.”

(Lieberman & Van Horn, 2008)

What is a two-generation approach?



Two-generation approaches provide opportunities for and meet the needs of vulnerable children and their parents together.

Developing a Clinical Formulation

After the initial referral, diagnostic interviews, and entry into the program, our first goal is to further develop a clinical formulation. Given the acuity of illness, and the intensive and brief treatment model of MBDH, it is important to have a working understanding of two questions:

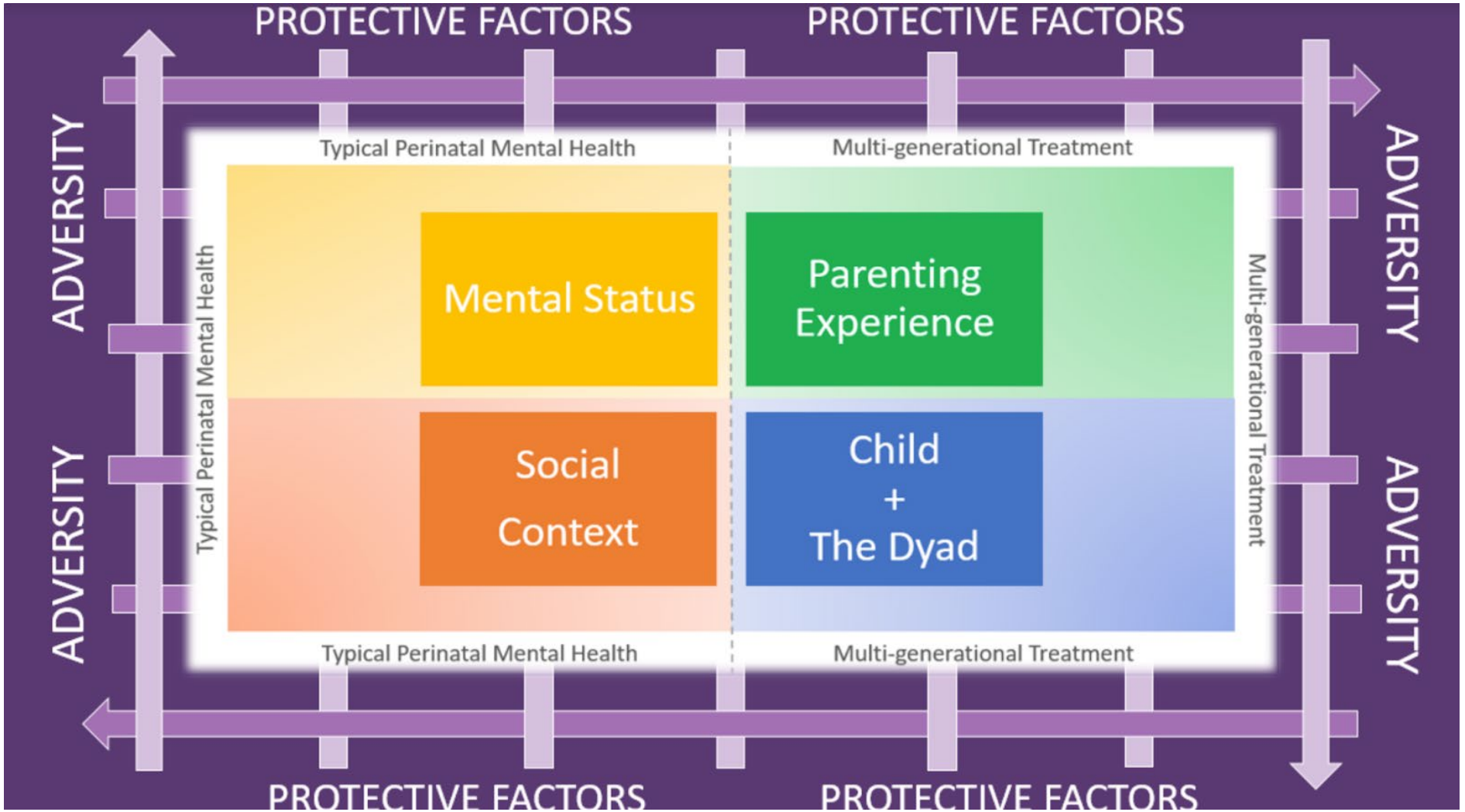
1) *What is contributing to the mother's distress? Child's distress?*
2) *How can we help?*

Our formulation is always integrative, trauma-informed, and strengths-based; we focus on the interacting factors that contribute to the present crisis, as well as the factors that contribute to relief and healing.

The Mother-Baby Four-Square

- The Mother-Baby Four-Square aids in developing our clinical formulation;
- It bridges a traditional perinatal mental health approach (i.e., “the left side”) with a multi-intergenerational approach that actively examines parental experiences (i.e., “the right side”);
- In addition, the Four-Square recognizes the impact of adversity (i.e., risks) and the mediating potential of protective experiences and relationships;
- Importantly, this clinical tool is dynamic: past influences present, mental distress impacts parenting, environmental risks can be offset by positive experiences, and social support contributes to healing;
- The Four-Square is also dynamic because, as mothers engage in treatment, more is learned and understood.

Mother-Baby Four-Square



Redleaf Center
For Family Healing

Quadrant #1: Mental Status

In this quadrant, we consider:

- what we know about the mother's current symptoms, impairment, diagnostic history, lifetime stress, and trauma exposure;
- the mother's baseline functioning in order to understand the degree of functional change associated with this acute episode (because the patient is in the midst of a significant developmental shift due to pregnancy or new motherhood, comparisons with baseline functioning must be adjusted accordingly).

Redleaf Center
For Family Healing

Quadrant #2: Social Context

In this quadrant we consider:

- the significant social supports in the mother's life and hypotheses about where social support can be cultivated;
- broader community-level and environmental protective and risk factors (e.g., socioeconomic and cultural experiences);
- the mother's racial identity and how this has impacted her in both positive and difficult ways, as well as how it may come up in the mother's relationship with the clinical team and other group members.

Redleaf Center
For Family Healing

Quadrant #3: Parenting Experience

In this quadrant, we consider:

- the mother's particular ghosts or angels from the nursery;
- how a mother's early relational history intersects with her current distress;
- hypotheses about her strengths and vulnerabilities in parenting her child(ren);
- her narrative of being parented (i.e., attachment history) informs the mother's current state of mind about relying on others and being reliable to her baby.

Redleaf Center
For Family Healing

Quadrant #4: Child + Dyad

In this quadrant, we consider:

- the mother's pregnancy, both medically and psychologically;
- how the baby is feeding and sleeping; the baby's emerging temperament; and how these factors either support and/or hinder the mother-baby relationship;
- other medical or developmental concerns for the child, particularly how the child signals distress and how the mother responds;
- *how* the mother talks about the baby, whether in utero or after birth.

The Weaving Around the Four-Square

- Represent the intersecting adverse and protective factors that may contribute to risk and resilience for each mother or dyad;
- Risk factors are adverse or traumatizing events, experiences, or relationships that have negatively influenced a mother's life and contribute to both short and long-term distress or dysfunction;
- Protective factors are positive or growth supporting experiences and relationships that mothers can count on as sources of strength and resilience (both objectively assessed but subjectively recognized).

Redleaf Center
For Family Healing

Questions?

Clinical Resources

- MGH Center for Women's Mental Health for meds and general info
- Mother to Baby Helpful factsheets.
- Reprotox for medication questions. App is free for trainees!
- Postpartum Support International and PPSM
- mcpapformoms.org: toolkits for perinatal co-occurring disorders
- Tips for Partners: https://www.postpartum.net/get-help/family/

HennepinHealthcare

Redleaf Center
For Family Healing

IECMH Resources

- Early childhood mental health system of care / Minnesota Department of Human Services (mn.gov)
- DC:0–5™ Manual and Training | ZERO TO THREE
- PCIT.org Parent Child Interaction Therapy
- www.abcintervention.org
- HOME – Child-Parent Psychotherapy (childparentpsychotherapy.com)
- About SPACE | SPACE Treatment
- Homepage - Circle of Security International

Redleaf Center
For Family Healing

Mother-Baby Program HopeLine

612-873-4673

(HOPE)

- Warmline, not a crisis line
- Speak to licensed mental health professional
- Mental health triage & connection with resources
- For pregnant women and parents of children 0-5, and providers
- If appropriate, will schedule an appointment with a perinatal psychiatrist or therapist at MB Program or referral to someone else
- Call: 612 873 HOPE (4673)
- Online referral form: https://redleaffamilyhealing.org/

Minnesota resources for Perinatal Mood and Anxiety Disorders

https://www.health.state.mn.us/people/womeninfants/pmad/index.html

Pregnancy Postpartum Support Minnesota

https://ppsupportmn.org/

Other resources:

Postpartum Support International

https://www.postpartum.net/get-help/psi-online-support-meetings/

Referral Options

Mental Health Services

- Washburn Center for Children
- Fraser
- Canvas Health
- St. David's
- Wilder
- Relate
- Family Innovations

- **Family Home Visiting**

Family Home Visiting Program - MN Dept. of Health (state.mn.us)

- **Early Intervention**

Refer a Child - Help Me Grow MN

- **Early Childhood Family Education/Special Education**

Early Childhood Family Education (mn.gov)

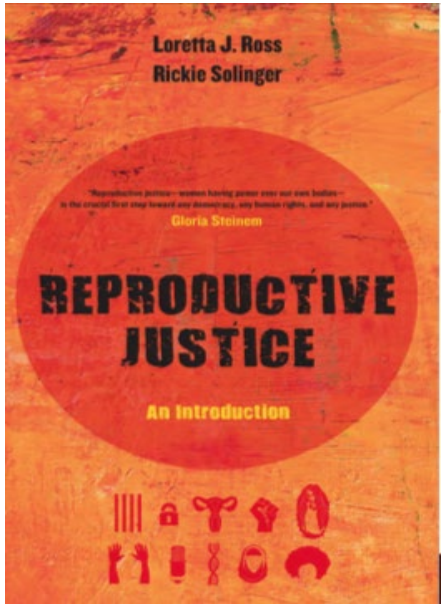
Future Learning

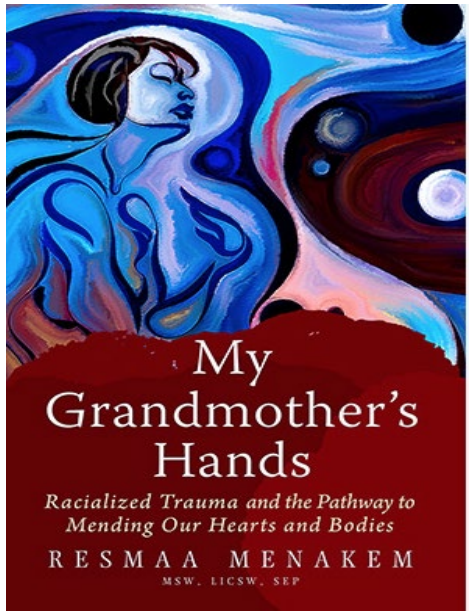
- MACMH Infant and Early Childhood Conference – Fall 2024
- Postpartum Support International
- Infant and Early Childhood certificate program at U of M
  - https://icd.umn.edu/academics/infant-and-early-childhood-mental-health/
- Circle of Security-Parenting circleofsecurityinternational.com

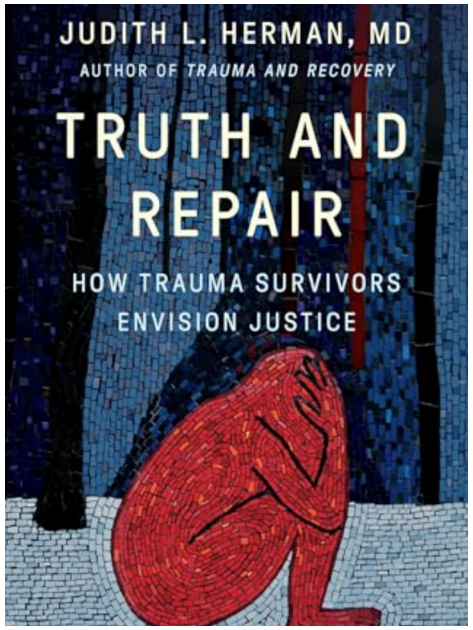
lorettajross.com

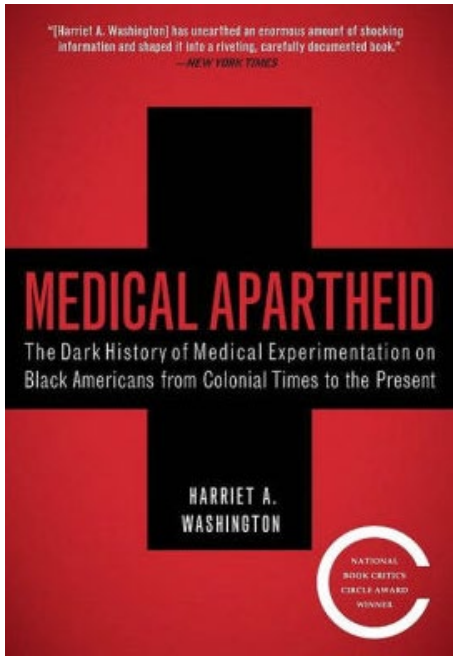
Calling In Conversations: Within Organizations | May 2023

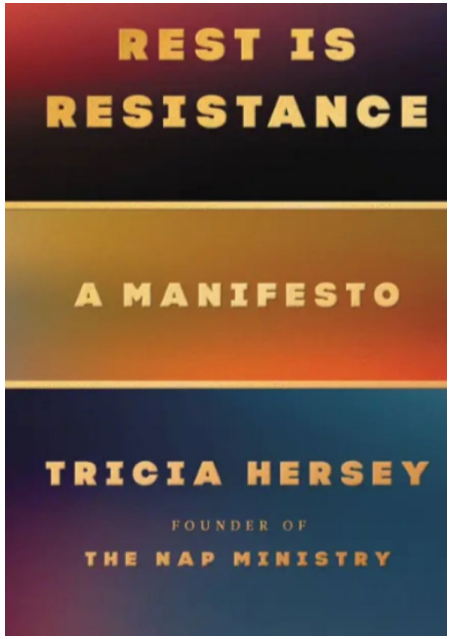
Calling In: Creating Change Without Cancel Culture by Loretta J. Ross



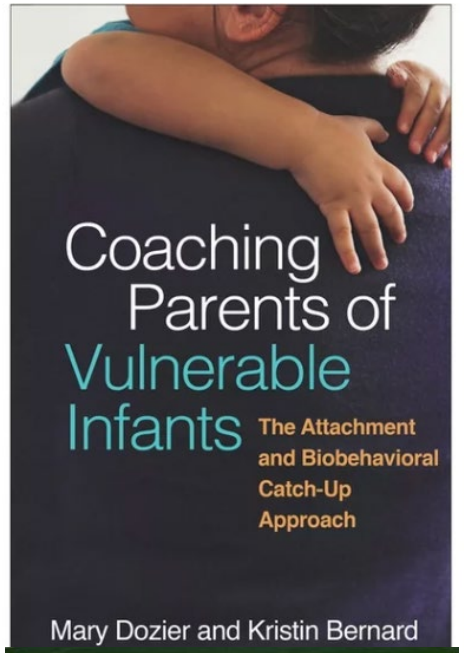


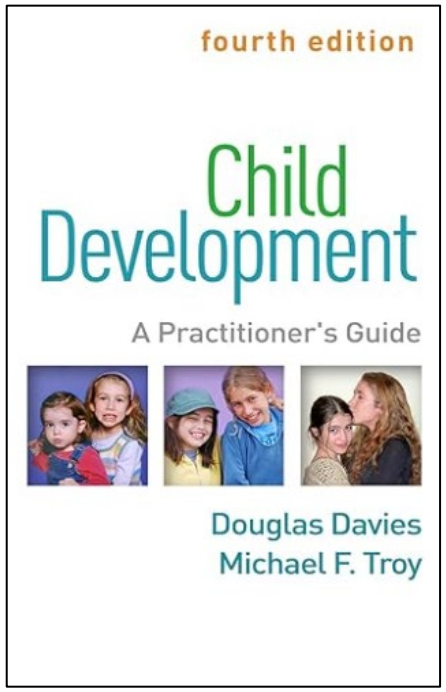


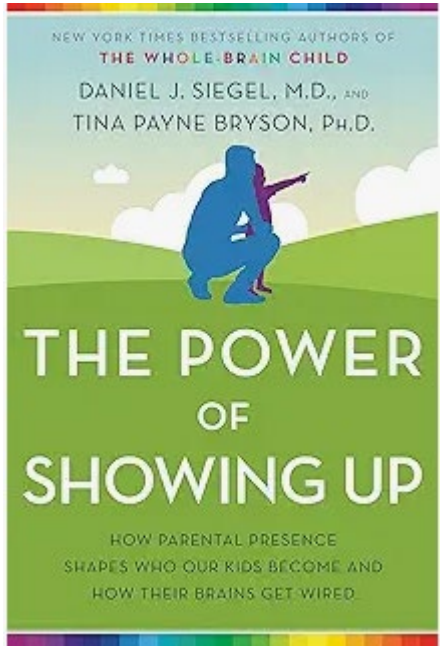


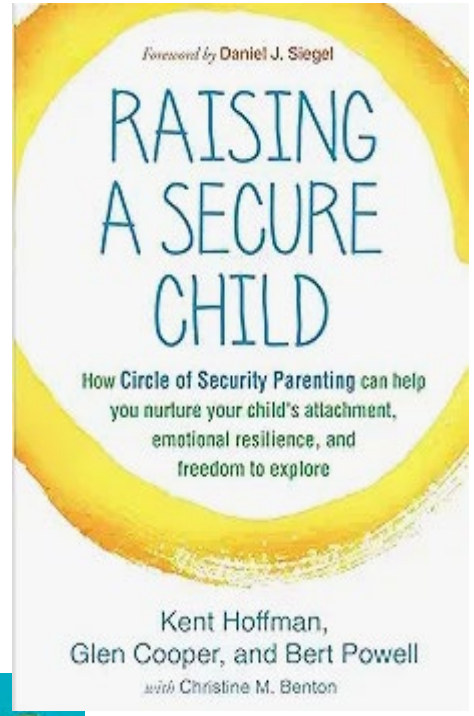


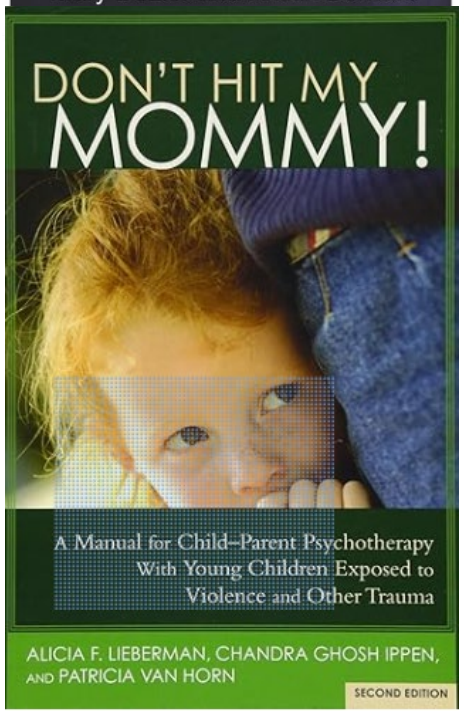
Books

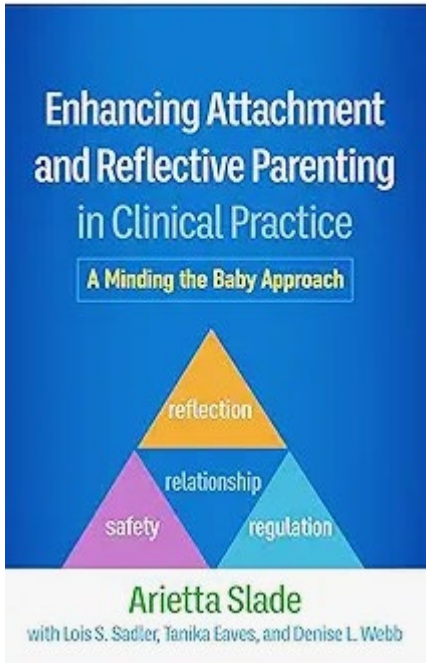

Coaching Parents of Vulnerable Infants
The Attachment and Biobehavioral Catch-Up Approach
Mary Dozier and Kristin Bernard

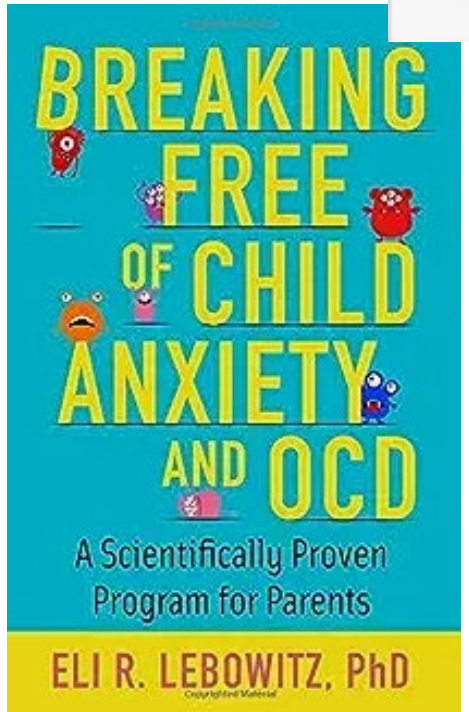

fourth edition
Child Development
A Practitioner's Guide
Douglas Davies
Michael F. Troy


NEW YORK TIMES BESTSELLING AUTHORS OF
THE WHOLE-BRAIN CHILD
DANIEL J. SIEGEL, M.D., AND
TINA PAYNE BRYSON, PH.D.
THE POWER OF SHOWING UP
HOW PARENTAL PRESENCE SHAPES WHO OUR KIDS BECOME AND HOW THEIR BRAINS GET WIRED


Foreword by Daniel J. Siegel
RAISING A SECURE CHILD
How Circle of Security Parenting can help you nurture your child's attachment, emotional resilience, and freedom to explore
Kent Hoffman,
Glen Cooper, and Bert Powell
with Christine M. Benton


DON'T HIT MY MOMMY!
A Manual for Child–Parent Psychotherapy With Young Children Exposed to Violence and Other Trauma
ALICIA F. LIEBERMAN, CHANDRA GHOSH IPPEN, AND PATRICIA VAN HORN
SECOND EDITION


Enhancing Attachment and Reflective Parenting in Clinical Practice
A Minding the Baby Approach
reflection
relationship
safety
regulation
Arietta Slade
with Lois S. Sadler, Tanika Eaves, and Denise L. Webb


BREAKING FREE OF CHILD ANXIETY AND OCD
A Scientifically Proven Program for Parents
ELI R. LEBOWITZ, PhD