Part 2: Complex PTSD

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Complex PTSD

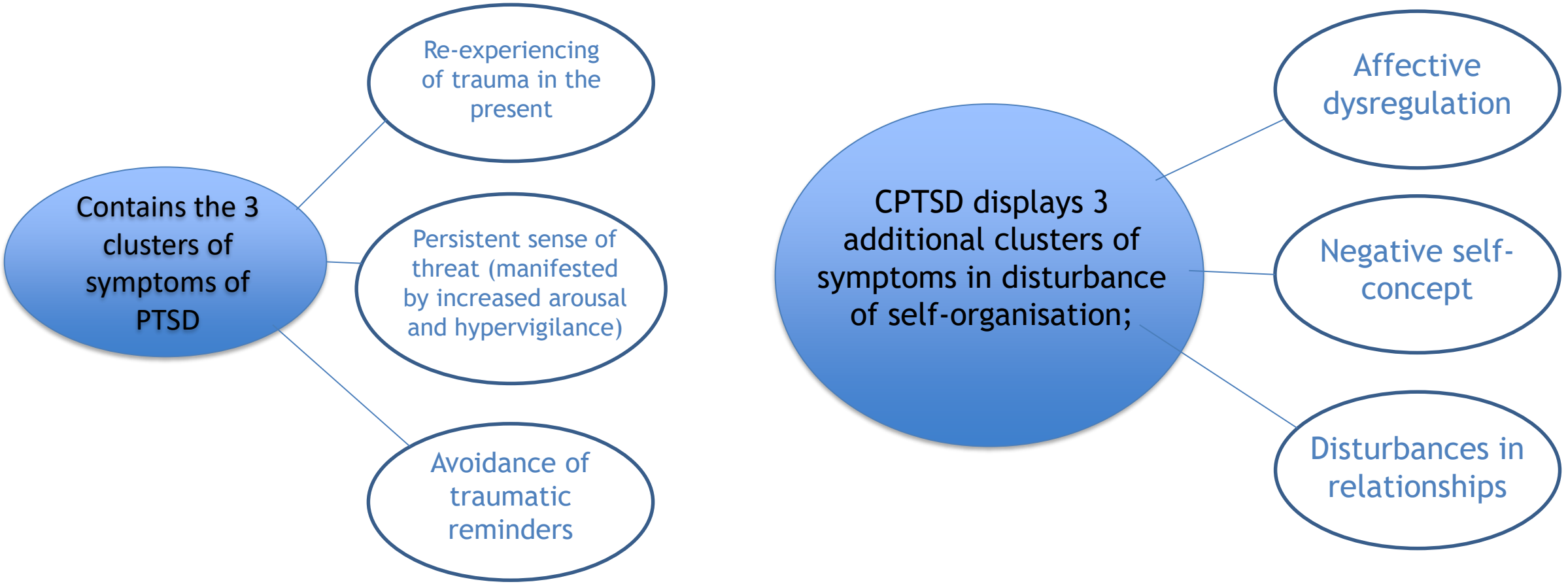
Complex PTSD (ICD-11)

- New addition to ICD-11
- Likely to occur as a result of trauma exposure that is:
- Inter-personal, prolonged, and/or repeated
- Escape from the trauma is difficult/impossible

'Complex post-traumatic stress disorder (complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible e.g. torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse' (Bisson, 2019)

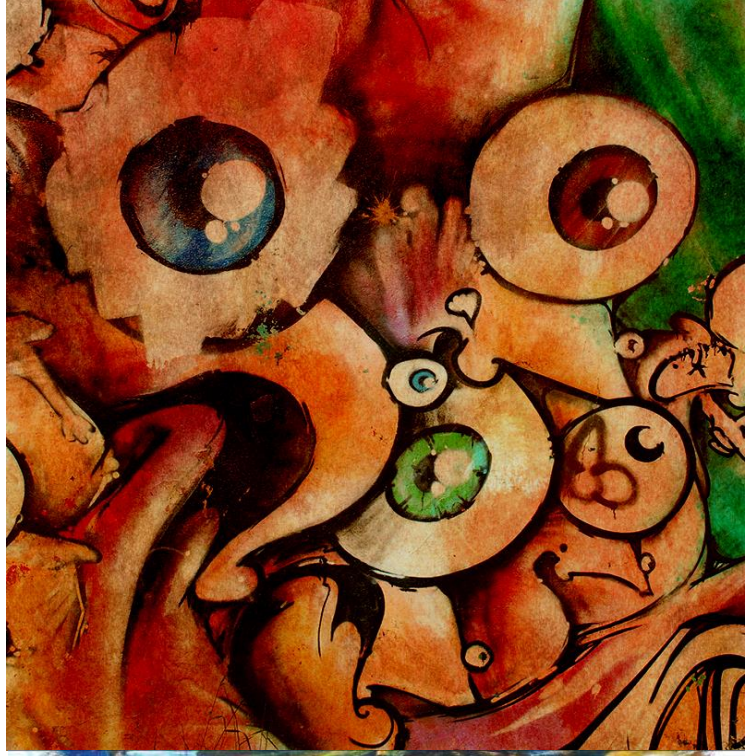
Complex PTSD (ICD-11)

Developmental trauma in children and young people often precedes CPTSD in the perinatal period.
Especially in at risk populations (e.g. care leavers, CYP exposed to repeated/prolonged maltreatment)



Complex Perinatal PTSD

- A recent UK study found prevalence rates of 2.1% for PTSD and 5.1% for CPTSD (Karatzias et al., 2017)
- Little is known about the prevalence of ICD-11 CPTSD during the perinatal period
- On-going programme of work in Cardiff, between 5-6% of women are identified as probable cases on the ITQ
- For childhood sexual abuse survivors, trauma memories can be easily triggered by the maternity setting e.g. physical examinations, touching, vaginal/breast pain, sense of loss of control, power imbalances (Montgomery et al., 2015)

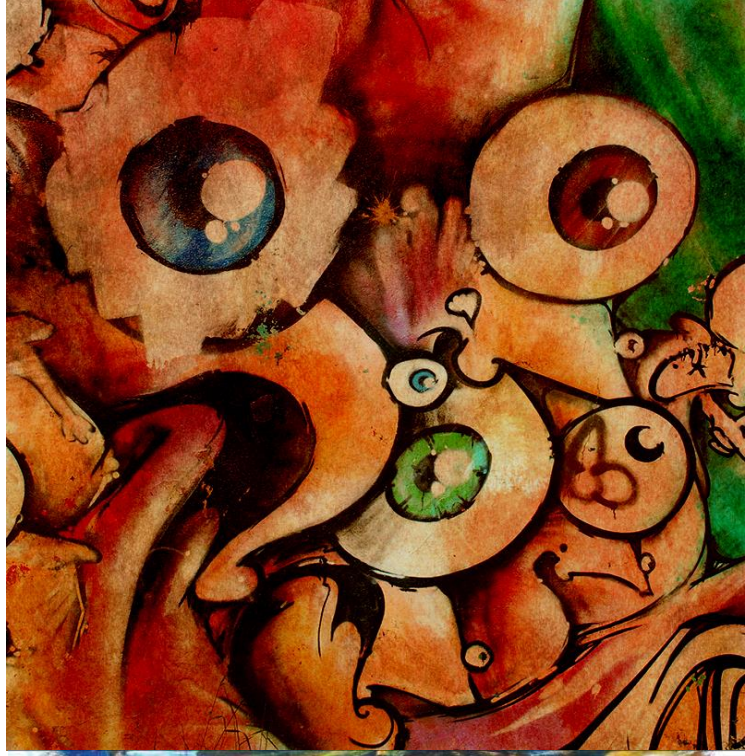


Complex Perinatal PTSD

- The link between childhood trauma and the activation/ exacerbation of PTSD/CPTSD symptoms during the perinatal period has long been recognised:

'In every nursery there are ghosts. They are the visitors from the unremembered past of the parents, the uninvited guests at the christening…….Even among families where the love bonds are stable and strong, the intruders from the parental past may break through the magic circle in an unguarded moment, and a parent and his child may find themselves re-enacting a moment or a scene from another time with another set of characters'

(Fraiberg et al., 1976)



Complex PTSD in the Perinatal Period

- **484 in survey so far (**NHS = 107: Open/Non-targeted = 377)

39 with probable PTSD/CPTSD on ITQ:

- 39 of 484 have PTSD/CPTSD = 8.1%
- Of 13 with PTSD (2.7%), only 6 (46%) were diagnosed with PTSD in the current perinatal period
- Of 26 with CPTSD (5.4%), only 6 (23%) were diagnosed with PTSD in the current perinatal period.

https://www.ncmh.info/2017/06/29/perinatal-mental-health-survey-launched/

NCMH
National Centre for Mental Health

Cymraeg

Help with our maternal

Conceptualisation Issues
Complex Trauma and the Perinatal Period

- 50 - 80% of MBU admissions (typically the most severe cases in perinatal mental health services) have a history of childhood maltreatment
- Strong association between childhood trauma and 'Borderline PD'
- 30% of maltreated children develop 'BPD' (eg. Bornovalova et al 2013)
- Earlier abuse worse effects (van der Kolk *et al*, 1994)
- 80% of infants of 'BPD' mothers are disorganized in their attachment at 13 months (Hobson, Patrick, Crandell et al 2005)
- Similar percentage of disorganised attachment is found in maltreated children (Carlson, Cicchetti, Barnett, & Braunwald, 1989)
- Are many of those diagnosed with BPD better conceptualised as CPTSD?

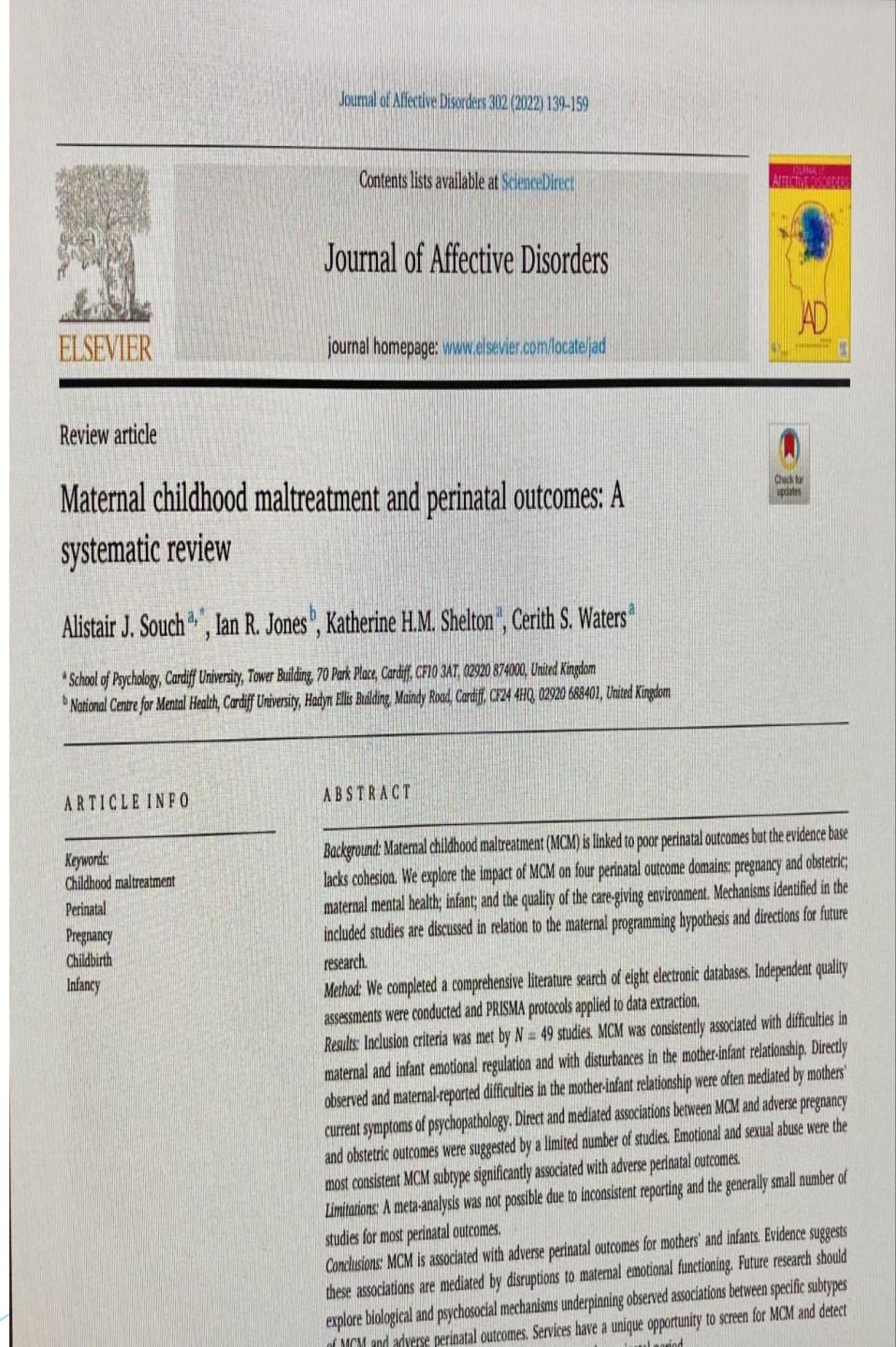
Systematic review

(Souch, Jones, Shelton & Waters)

- A systematic review was conducted to assess the impact of a history of maternal childhood maltreatment (MCM) on outcomes during the perinatal period
- CPTSD not measured in the literature

Childhood maltreatment defined as (WHO, 2016):

- The abuse and neglect that occurs to children under 18 years of age
- All types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and exploitation.
- The maltreatment must results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power



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Review article

Maternal childhood maltreatment and perinatal outcomes: A systematic review

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Childbirth
Infancy

ABSTRACT

Background: Maternal childhood maltreatment (MCM) is linked to poor perinatal outcomes but the evidence base lacks cohesion. We explore the impact of MCM on four perinatal outcome domains: pregnancy and obstetric; maternal mental health; infant; and the quality of the care-giving environment. Mechanisms identified in the included studies are discussed in relation to the maternal programming hypothesis and directions for future research.

Method: We completed a comprehensive literature search of eight electronic databases. Independent quality assessments were conducted and PRISMA protocols applied to data extraction.

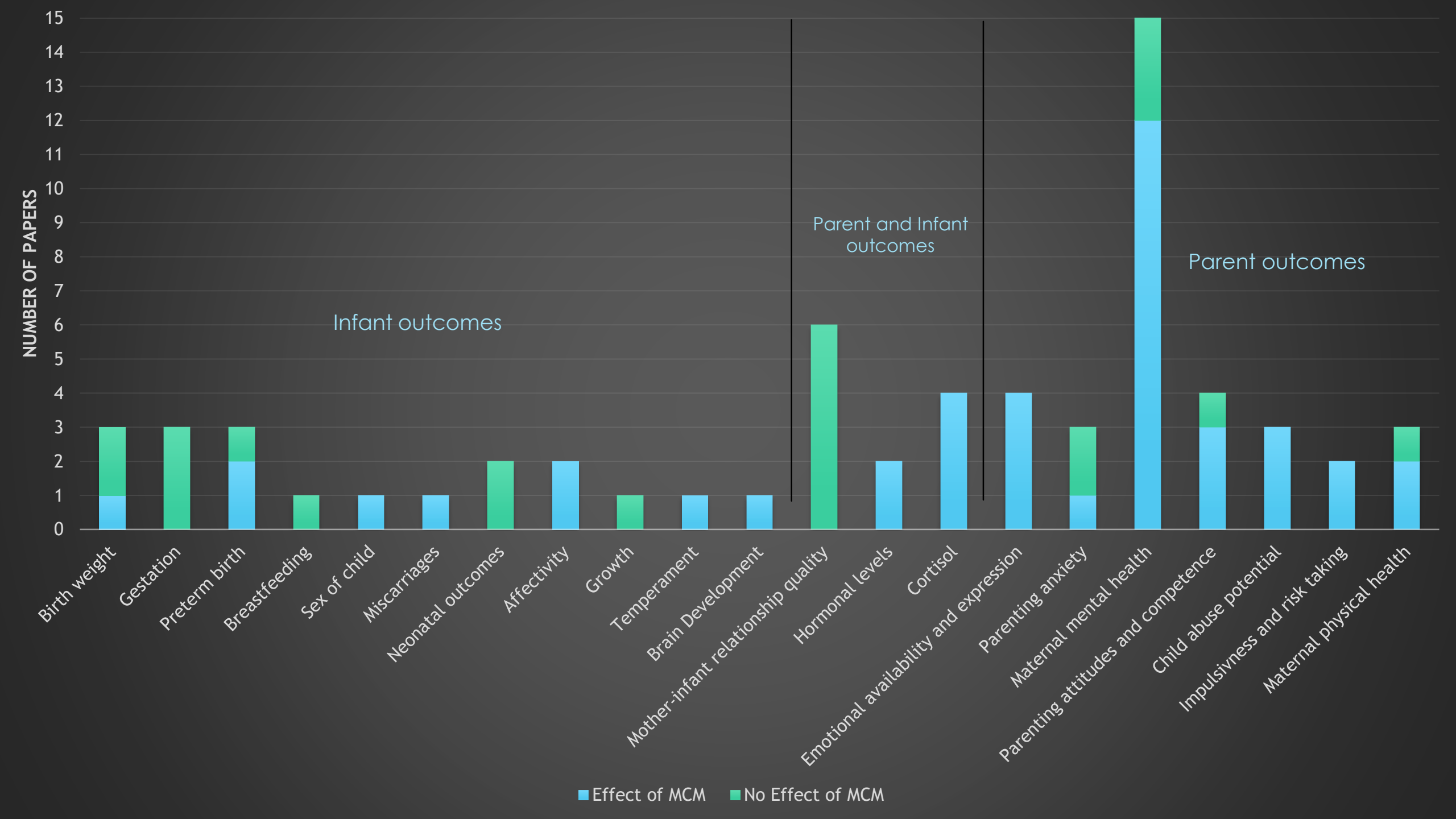
Results: Inclusion criteria was met by $N = 49$ studies. MCM was consistently associated with difficulties in maternal and infant emotional regulation and with disturbances in the mother-infant relationship. Directly observed and maternal-reported difficulties in the mother-infant relationship were often mediated by mothers' current symptoms of psychopathology. Direct and mediated associations between MCM and adverse pregnancy and obstetric outcomes were suggested by a limited number of studies. Emotional and sexual abuse were the most consistent MCM subtype significantly associated with adverse perinatal outcomes.

Limitations: A meta-analysis was not possible due to inconsistent reporting and the generally small number of studies for most perinatal outcomes.

Conclusions: MCM is associated with adverse perinatal outcomes for mothers' and infants. Evidence suggests these associations are mediated by disruptions to maternal emotional functioning. Future research should explore biological and psychosocial mechanisms underpinning observed associations between specific subtypes of MCM and adverse perinatal outcomes. Services have a unique opportunity to screen for MCM and detect

Findings

- Inclusion criteria was met by *N* = 49 studies.
- Outcomes grouped into domains: pregnancy and obstetric; maternal mental health; infant; and the quality of the care-giving environment. Mechanisms identified in the included studies are discussed in relation to the maternal programming hypothesis and directions for future research.
- MCM was consistently associated with difficulties in maternal and infant emotional regulation and with disturbances in the mother-infant relationship.
- Minimal evidence for an association between MCM and pregnancy/obstetric outcomes e.g. pre-term birth, miscarriage, APGAR scores etc.
- Directly observed and maternal-reported difficulties in the mother-infant relationship were often mediated by mothers' current symptoms of psychopathology.
- Direct and mediated associations between MCM and adverse pregnancy and obstetric outcomes were suggested by a limited number of studies.
- Emotional and sexual abuse were the most consistent MCM subtype significantly associated with adverse perinatal outcomes.


NUMBER OF PAPERS
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Infant outcomes
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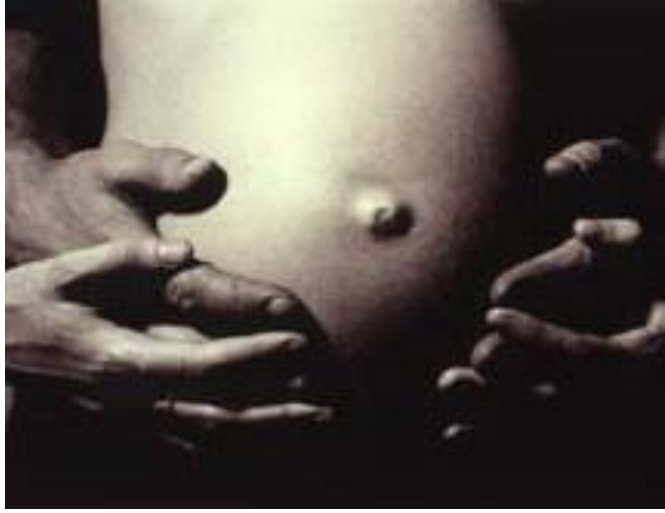
Parent outcomes
Birth weight
Gestation
Preterm birth
Breastfeeding
Sex of child
Miscarriages
Neonatal outcomes
Affectivity
Growth
Temperament
Brain Development
Mother-infant relationship quality
Hormonal levels
Cortisol
Emotional availability and expression
Parenting anxiety
Maternal mental health
Parenting attitudes and competence
Child abuse potential
Impulsiveness and risk taking
Maternal physical health
Effect of MCM
No Effect of MCM

Review limitations

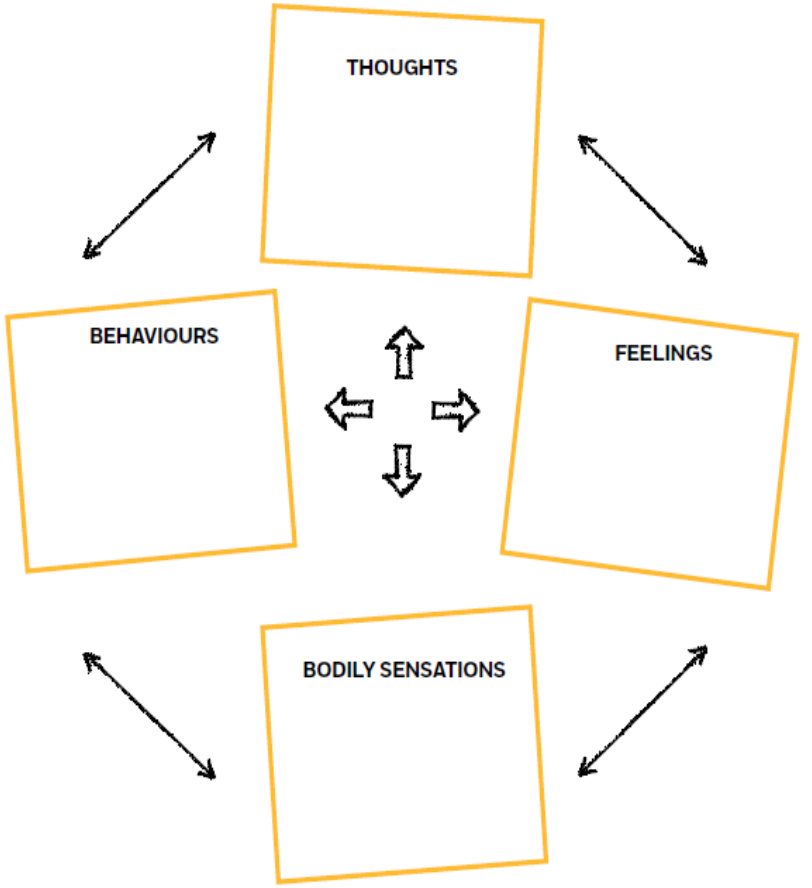
- A variety of measures were used to capture childhood maltreatment as well as measuring outcomes such as mother-infant relationship quality
- Therefore we can't be certain all aspects of childhood maltreatment

  and all aspects of mother and/or infant outcomes are captured
- These outcomes were also captured at different time points within the perinatal period, making comparisons hard
- There were a small number of papers exploring each outcome, and inconsistent presentation of results meant a meta-analysis was not possible
- There is a lack of clarity amongst studies as to which variable are controlled for

Psychological Assessment/Formulation



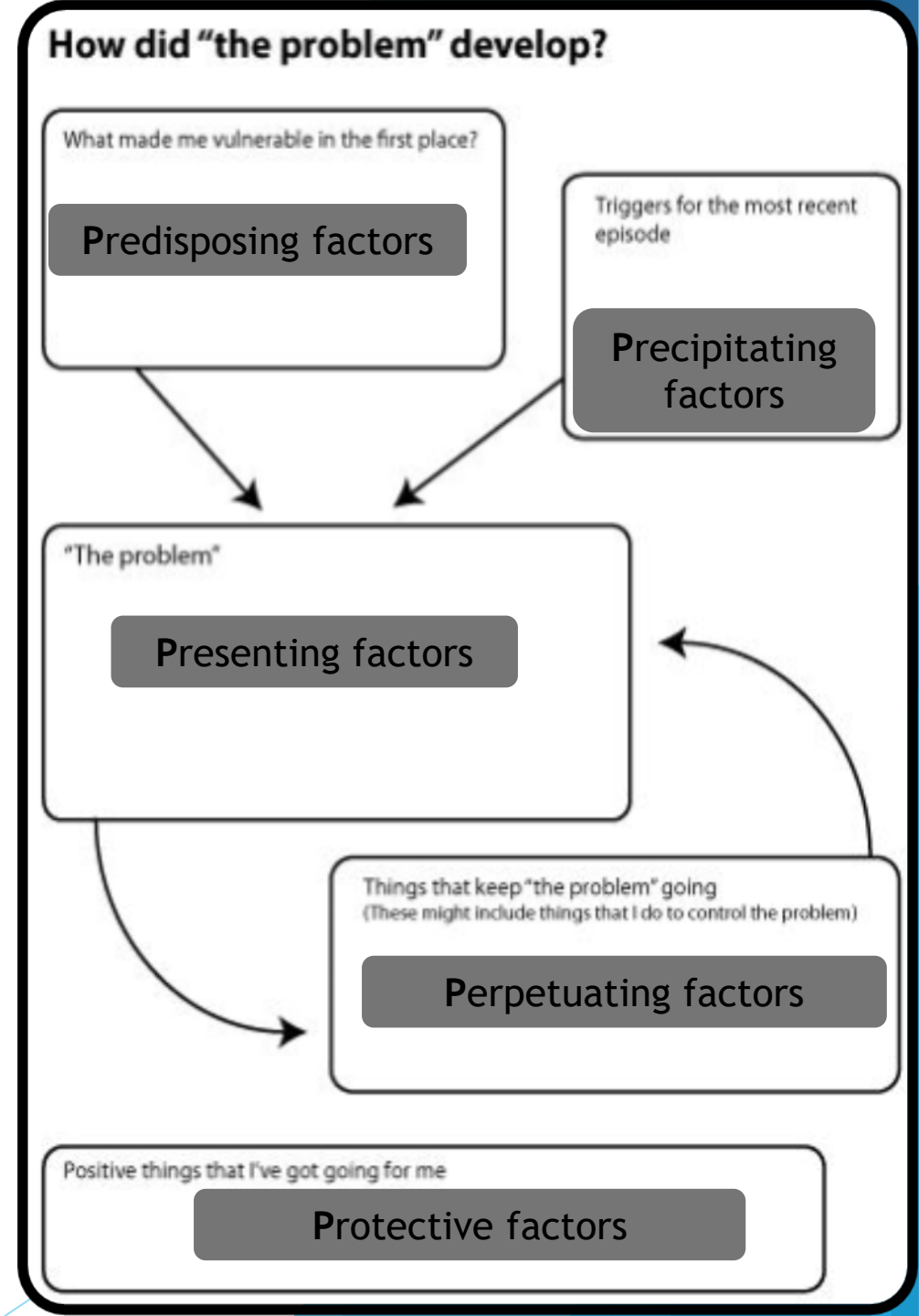
- Pregnant vs Postnatal
- Holistic (part 2 mental health measure) – care and treatment plan
- Timing, frequency, severity, duration of trauma exposure – trauma timeline helpful
- Medical/pregnancy complications
- Typically integrative at the initial assessment, moving to model specific for particular symptom clusters/interventions
- Always discuss risks/benefits of different treatment options
- Always relationship focused & co-constructed



Psychological Assessment/ Formulation

Methods

- Clinical Interview
- Case note review, colleagues assessments
- ITQ, CORE-30, GAD7, EPDS, PBQ, Risk Assessment e.g. WARRN if indicated, direct observation of parent-infant relationship
- Multiple theories/interventions from different models could be used at different points in the perinatal period (e.g. stabilisation in pregnancy, trauma focused post-natally + parent-infant focused intervention)
- Attachment theory, Systems theory, Social learning theory, Cognitive-behaviour theory, Person-centred Psychology, Evolutionary/CFT, DBT/ACT, CAT



Complex PTSD

Assessment and Formulation

- Initial process the same BUT sequence (phases) of interventions can differ for CPTSD v PTSD
- If NOT CPTSD then TF psychological therapies
- IF CPTSD focus on Disorganisation of Self Organisation Cluster first (typically/not always) AND this cluster is often prioritised during formulation/intervention planning

If Complex PTSD:

- Often multi-disciplinary – Psychiatry, CPN, Psychology, Specialist Midwifery, Nursery Nurse
- Often (but not always) psychiatric, psycho-social and psychological interventions
- Nursery Nurse input beginning in pregnancy
- Inter-agency – safe guarding, social services, older children
- Extended stabilisation and preparation phase, especially if pregnant
- Depending on a number of factors (e.g. social context, safety, weeks gestation etc.) often focus to stay at phase 1 during pregnancy (but not always)

Complex PTSD

Phase One

- Cost-benefits discussion with the service user to agree intervention plan and readiness for different interventions
- Often focus on extended phase 1 interventions first (stabilisation) if late pregnancy or early postnatal, birth planning, MDT approach
- Practical/emotional support from nursery nurses to increase parenting self-efficacy and confidence in maternal role (increase social support, infant massage)

Phase Two

- Trauma-Focused CBT/EMDR
- Cognitive Analytic Psychotherapy (CAT)
- Integrative Psychological Therapy
- Couples Therapy
- Parent-Infant Psychotherapy (VIG, WWW, Play and Development group) – depending on intervention plan/time of referral/assessment etc.
- Medication

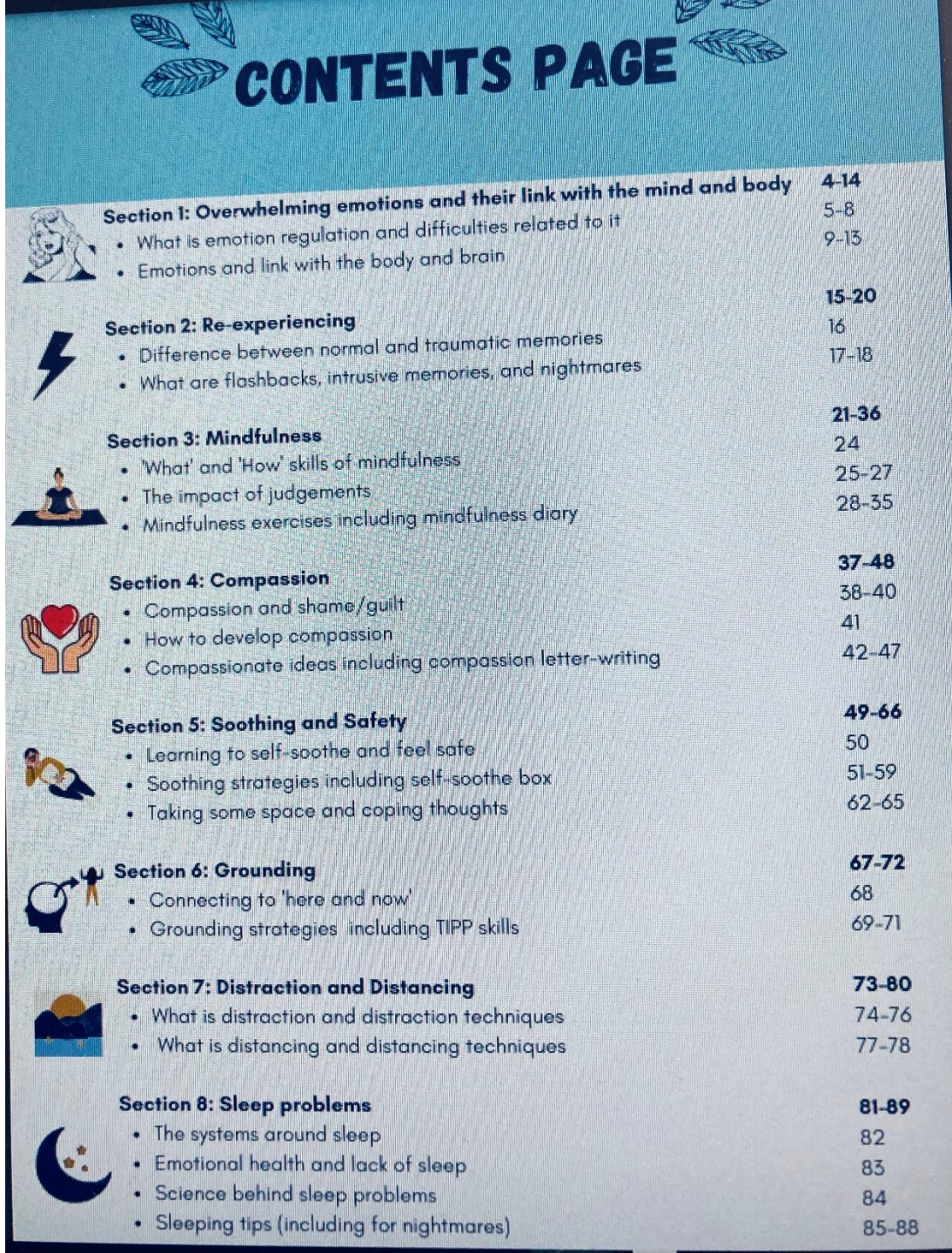
Reflections CPTSD

- An MDT approach is key: '*singing from the same hymn sheet'* and the challenges of splitting
- Assessment/Formulation/Intervention planning is critical
- Sequencing of co-constructed intervention plan (with built in flexibility) is critical
- Not infrequently phase 1/targeting Disorganisation of Self-Organisation symptoms is 'good enough'/the priority
- Recovery focused, '*here and now*' , increasing parental self-efficacy/confidence in the maternal role prioritised if postnatal e.g. during the early weeks following childbirth increased nursery nurse visits

Guided Self-Help for Managing Overwhelming Emotions

- 8 session Guided Self-help Intervention
- Delivered by CPNs, APs, Trainee CPs
- Pilot practice-based trial in CAV UHB and SB UHB
- Currently used in NHS specialist community services and in-patient MBUs

https://perinataltreatment.wordpress.com/workbook-for-women-who-have-experienced-trauma/



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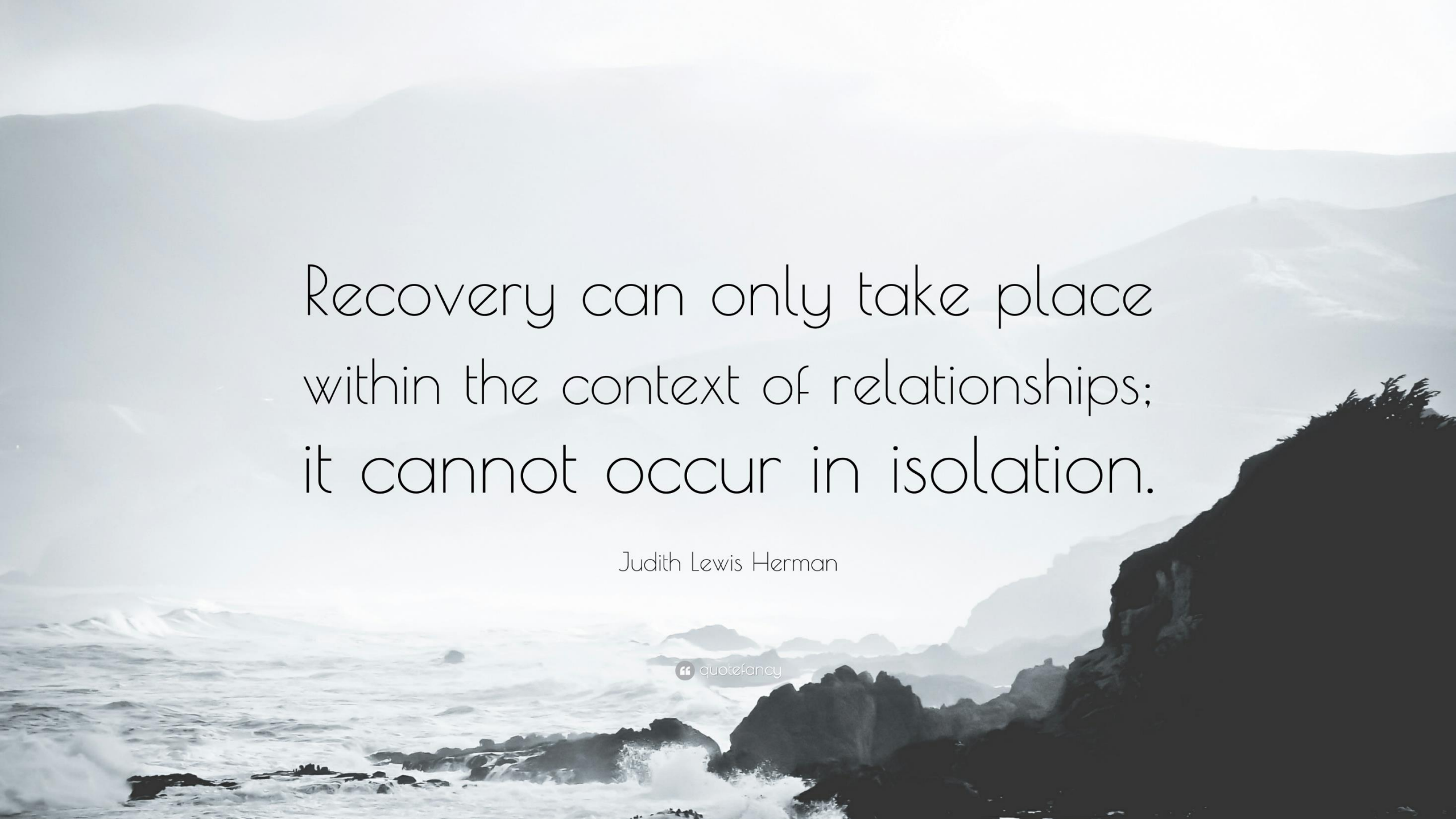

Recovery can only take place
within the context of relationships;
it cannot occur in isolation.
Judith Lewis Herman
quotefancy

Parent-Infant Interventions

Interventions with the best evidence (see NICE guidance 2015 for Children's Attachment)

1. **Video-interaction guidance (VIG)** - Hilary Kennedy – dyadic-triadic

https://www.videointeractionguidance.net/

2. **Video Feedback Intervention to Promote Positive Parenting (VIPP)** – dyadic-triadic

https://tavistockandportman.nhs.uk/research-and-innovation/our-research/research-projects/video-feedback-intervention-promote-positive-parenting-and-sensitive-discipline-research/

3. **Circles of Security (COS)** – group delivered, dyadic-triadic

https://www.circleofsecurityinternational.com/

4. **Parent-Infant Psychotherapy** - roots in psychoanalysis – Anna Freud - dyadic-triadic

https://www.annafreud.org/training/training-and-conferences-overview/training-at-the-anna-freud-national-centre-for-children-and-families/parent-infant-psychotherapy-specialist-training/

Parent-Infant Interventions

Interventions with the best evidence (see NICE guidance 2015 for Children's Attachment)

5. Watch Wait and Wonder (WWW) – dyadic/triadic

also in groups http://watchwaitandwonder.com/

6. Dyadic Developmental Psychotherapy (DDP) – dyadic-triadic and groups (Dan Hughes) - https://ddpnetwork.org/uk/

7.Theraplay – dyadic/triadic

https://www.theraplay.org/index.php/what-is-theraplay-3

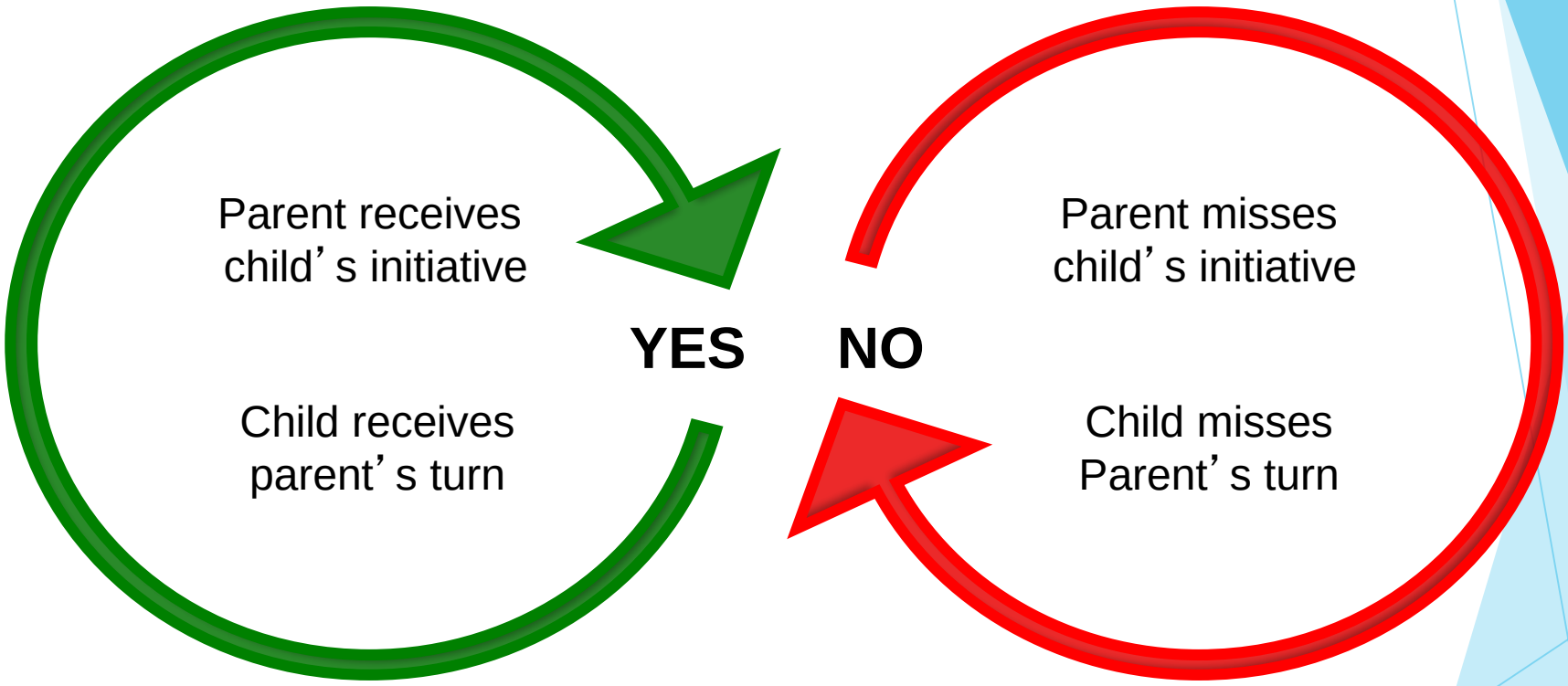
What is VIG?

- Uses short video of parent & child for reflection
- Developed to help families build successful communication
- Helps parents to identify their strengths and build on them
- Safe and empowering

What is VIG?

- Edit clips demonstrating good communication between parent and child (only select positive examples-building confidence)
- If the building blocks for effective communication are working well this builds their relationship
- Strong communication skills also help parents to manage difficult situations with their child
- Based on the work by Colwyn Trevarthen

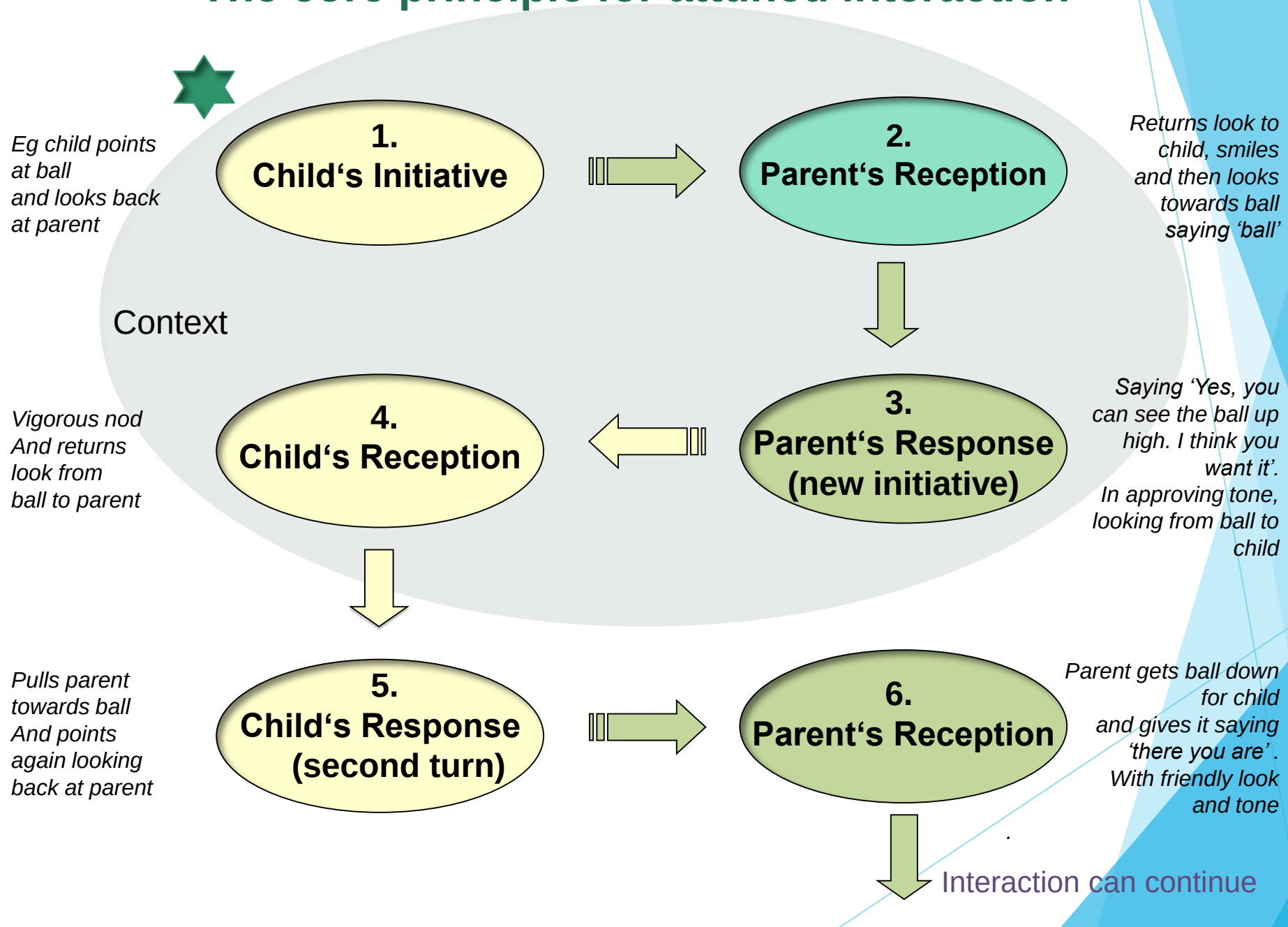
DOES PARENT RECEIVE CHILD'S INITIATIVE?



ATTUNED CYCLE

DISCORDANT CYCLE

The core principle for attuned interaction



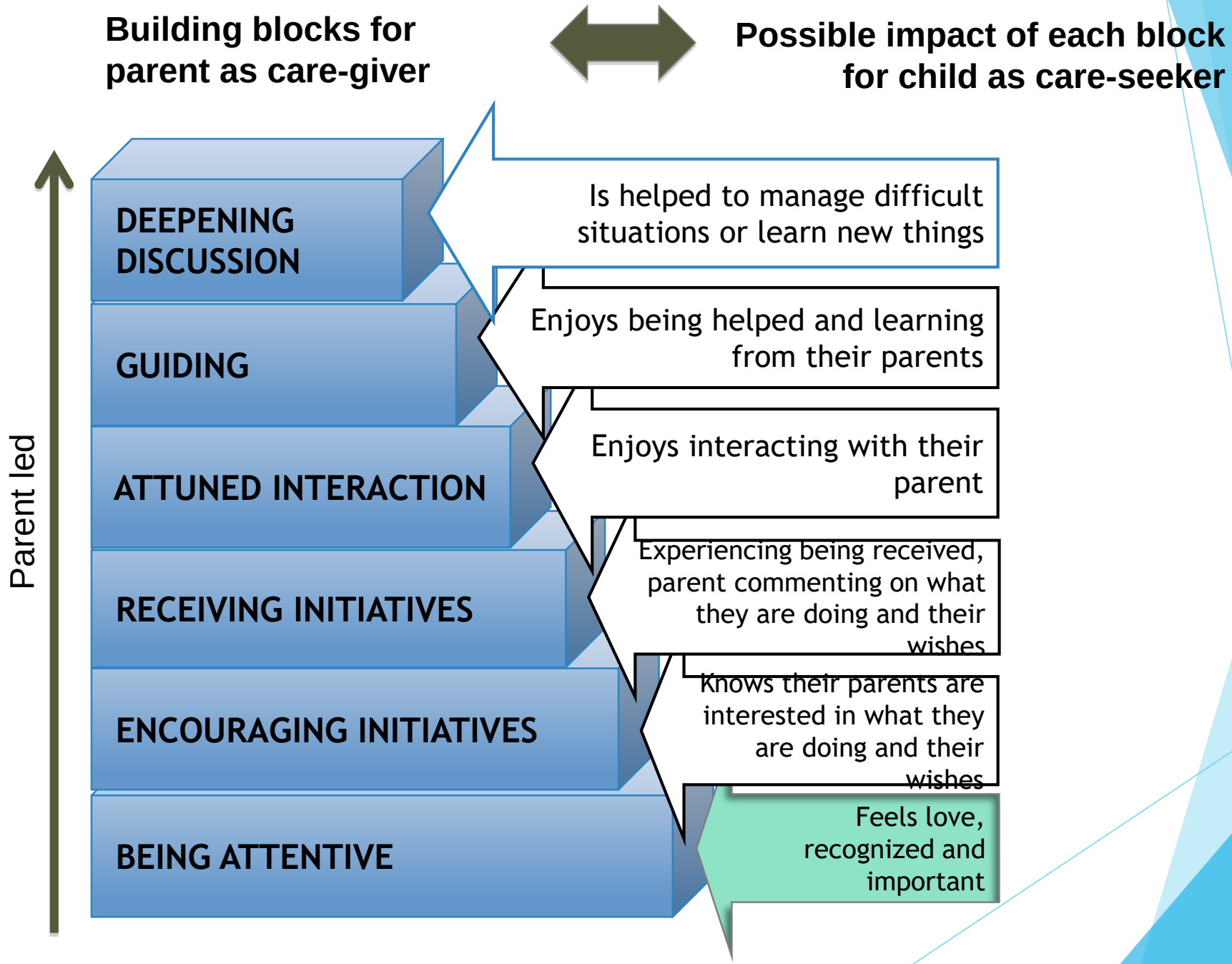

Building blocks for parent as care-giver
Possible impact of each block for child as care-seeker
Parent led
DEEPENING DISCUSSION
GUIDING
ATTUNED INTERACTION
RECEIVING INITIATIVES
ENCOURAGING INITIATIVES
BEING ATTENTIVE
Is helped to manage difficult situations or learn new things
Enjoys being helped and learning from their parents
Enjoys interacting with their parent
Experiencing being received, parent commenting on what they are doing and their wishes
Knows their parents are interested in what they are doing and their wishes
Feels love, recognized and important

Fig. 4 Principles of attuned interactions and guidance

Being attentive	• Looking interested with friendly posture • Giving time and space for other • Wondering about what they are doing, thinking or feeling • Enjoying watching them
Encouraging initiatives	• Waiting • Listening actively • Showing emotional warmth through intonation • Naming positively what you see, think or feel • Using friendly and/or playful intonation as appropriate • Saying what you are doing • Looking for initiatives
Receiving initiatives	• Showing you have heard, noticed their initiative • Receiving with body-language • Being friendly and/or playful as appropriate • Returning eye-contact, smiling, nodding in response • Receiving what they are saying or doing with words • Repeating/using their words or phrases
Developing Attuned interactions	• Receiving and then responding • Checking they are understanding you • Waiting attentively for your turn. • Having fun • Giving a second (and further) turn on same topic • Giving and taking short turns • Contributing to interaction / activity equally • Co-operating - helping each other
Guiding	• Scaffolding • Extending, building on their response • Judging the amount of support required and adjusting • Giving information when needed • Providing help when needed • Offering choices that they can understand • Making suggestions that they can follow
Deepening discussion	• Supporting goal-setting • Sharing viewpoints • Collaborative discussion and problem-solving • Naming difference of opinion. • Investigating the intentions behind words • Naming contradictions/conflicts (real or potential) • Reaching new shared understandings • Managing conflict (back to Being attentive and receive initiatives aiming to restore attuned interactions)

VIG Method 1: Initial meeting

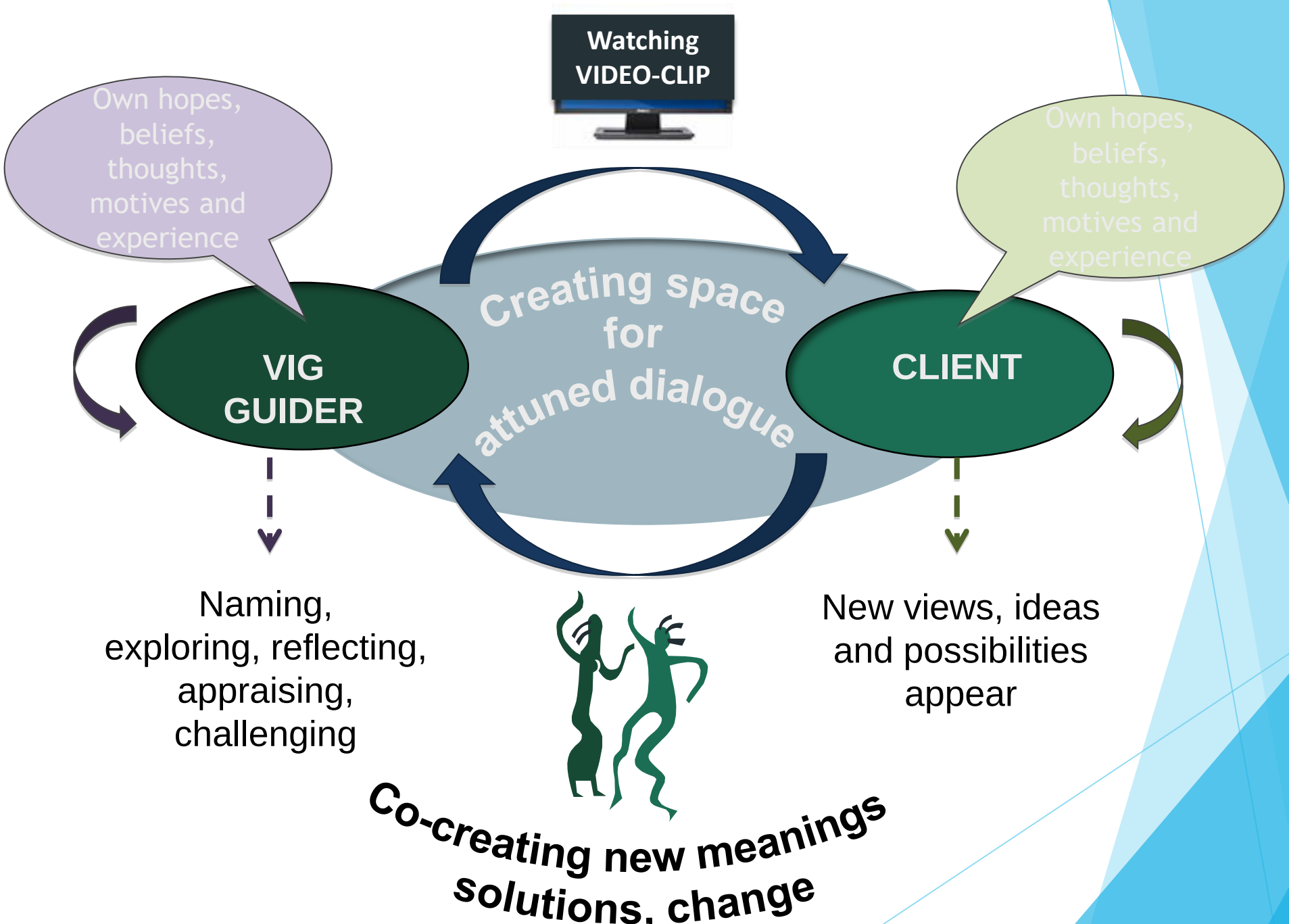
- Initial meeting: Listening carefully to worries and concerns
- Establish hope for the future
- Explain VIG: What it involves and how VIG links with the family's goals for change
- Setting interactive goal(s)

VIG Method 1: Take and edit the video

- Take video clip (10-15 minutes) of parent and child doing something together that involves communication
- Sometimes activate (coach) families to ensure success
- Choose 3 short clips (30-60 seconds of their best bits) to look at in the ‘shared review’

VIG Method 2: The shared review

- Feedback sessions last 45-60 mins
- Edited clips based on ‘attuned interaction’ and parents goals
- Show the clip and ask questions to ‘activate’ the parent:
  - What did you see?
  - How do you think your child felt?
  - What does that mean?


Watching
VIDEO-CLIP
Own hopes, beliefs, thoughts, motives and experience
Own hopes, beliefs, thoughts, motives and experience
Creating space for attuned dialogue
VIG
GUIDER
CLIENT
Naming, exploring, reflecting, appraising, challenging
New views, ideas and possibilities appear
Co-creating new meanings
solutions, change

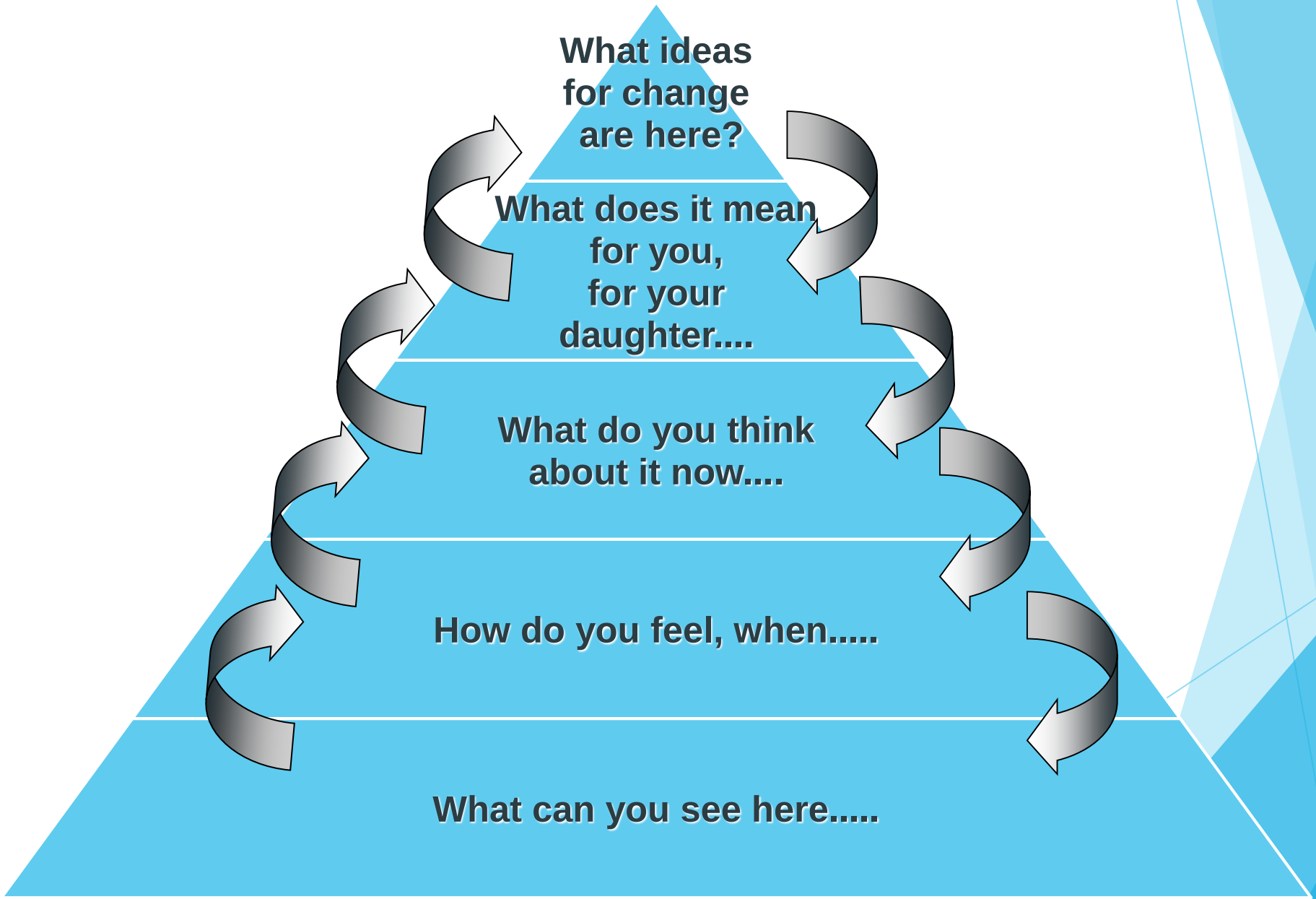
The experience of shared review

- VIG guiders use same principles of ‘attuned interactions’ to guide feedback
- This gives parents a direct experience of successful communication with another person
- Parents experience the feedback sessions positively

Examples of feedback questions

- What are you thinking / feeling there?
- How would you describe the way you're looking at him now?
- Where does this idea come from?
- How do you think that makes the child feel?
- Is that important? Why?

Scaffolding the meanings during the feedback



VIG Case Study

- Father: 26 year old, full-time employed
- Female girl, born prematurely following pre-eclampsia
- Traumatic birth resulted in maternal and paternal PTSD, depression and anxiety. Maternal treatment with EMDR in local perinatal service
- Age 1, baby girl suffered 3 cardiac arrests, diagnosed with a rare genetic heart condition, fitted with a mechanical device to prevent future arrests
- Father referred from neonatal outpatient services to the Gwent Parent-Infant Mental Health Service following concerns identified in the parent-infant relationship


MIDWIVES ARE CALLING YOU NOW
WE ARE
HAVING A MIDWIFE CRISIS
MIDWIVES MATTER
ADDRESS THE ELEPHANT IN THE WOMB
MIDWIVES ARE
SAVE THE MIDWIFE!!!
HIGH FIVES FOR MIDWIVES
GIVE US A BREAK!
MIDWIVES MATTER


WE ARE
MIDWIVES
HAVING A
MIDWIFE
CRISIS
SAVE
OUR
STAFFING

Royal College of Midwives (2021)

Annual Survey Findings

-'Midwives are being driven out of the NHS by understaffing and fears they can't deliver safe care to women in the current system'

-'Over half of midwives surveyed said they were considering leaving their job as a midwife with 57% saying they would leave the NHS in the next year'.

-'Eight out of 10 were concerned about staffing levels and two-thirds were not satisfied with the quality of care they are currently able to deliver.'

-'Over half of respondents said they did not feel valued by their employer. Almost all (92%) of midwives and maternity support workers (MSW) said that they did not feel their work was valued by the current UK Government.'

-Exodus of midwives from the NHS at the fastest rate since records began

-Newly qualified midwives are leaving (or not even entering) the profession at the highest rates of all age groups….

Moral Injury

In traumatic or unusually stressful circumstances, people may perpetrate, fail to prevent, or witness events that contradict deeply held moral beliefs and expectations.

A moral injury can occur in response to acting or witnessing behaviors that go against an individual's values and moral beliefs.

You are not on your own. What Midwives Say…….

From the USA

'Even as the pandemic eases, the mental health aftermath for our frontline health care providers will continue. But we should have no doubt that our profession is resilient. We will always find ways to honor our professional philosophy: to provide therapeutic human presence, in continuous and compassionate partnership, affirming the power and strength not only of our patients, but of ourselves'. (USA)

J Midwifery Womens Health. 2020 May 11 : 10.1111/jmwh.13121. doi: 10.1111/jmwh.13121

From Australia

'And the whole governance and having to have everything correct. I understand governance. But I think it's just sort of taken over, the fear pandemic. Management aren't always going to be in a space to listen'

'We lost our one-on-one continuity, which is very sad and we've seen the impacts of it pretty much immediately, we didn't get to keep the women that we've been looking after….It was very sad not to have had any warning about the changes. Why were we the first to go?'

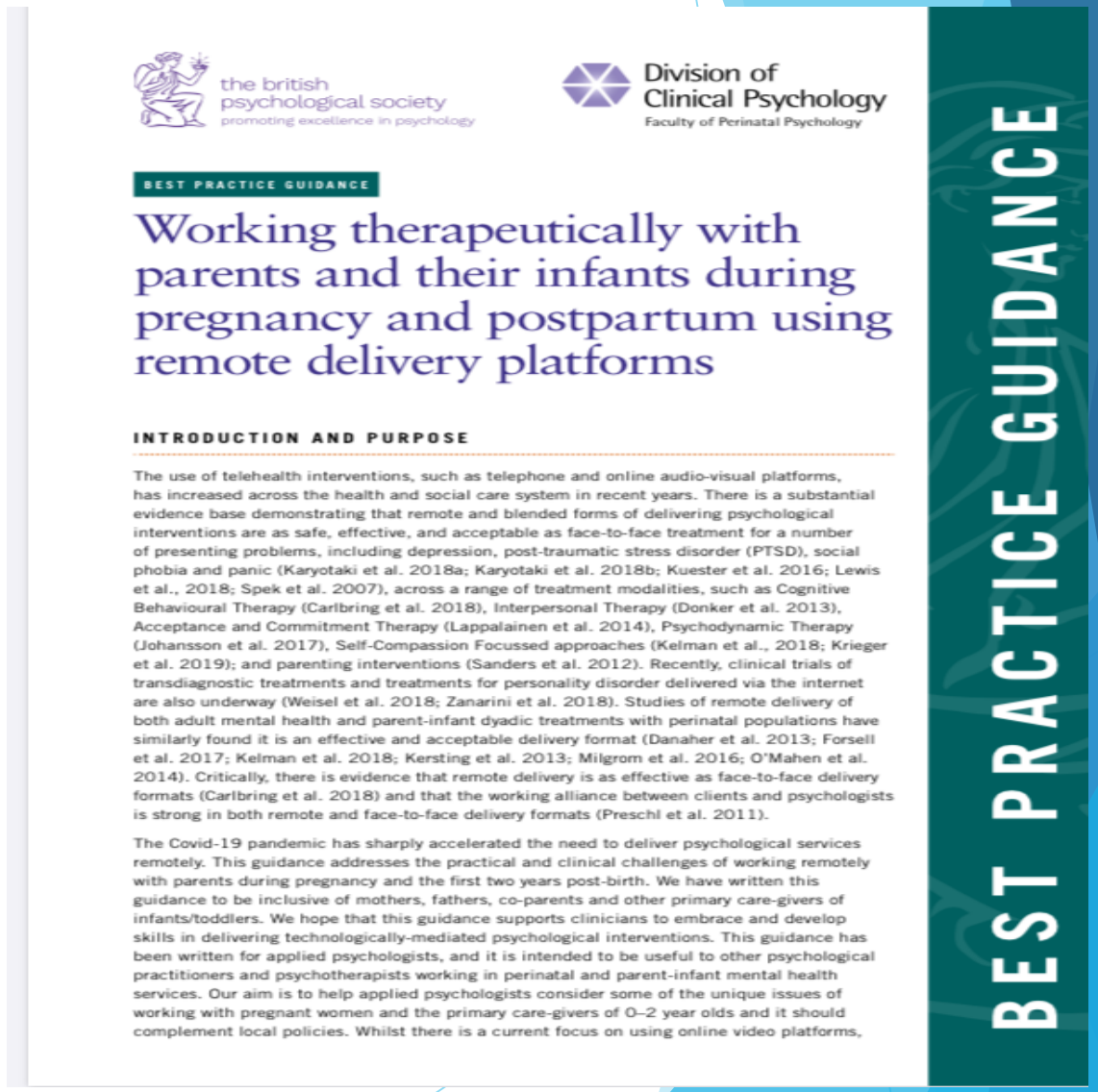
'It's really hard. It's not the same. You're not getting that connection. The women aren't really getting to know the whole team.'

BPS Guidance Covers for remote delivered psychological therapies during the perinatal period:

- Individualised
- Trauma Focused Interventions
- Couple Focused Interventions
- Parent-Infant Focused Interventions
- Group Delivered Interventions

Mycroft, Healy, O'Mahen, Rosan, Sharp, Slade & Tsefos, & Waters

https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Working%20remotely%20with%20parents%20and%20infants%20during%20pregnancy%20and%20postpartum.pdf



the british psychological society
promoting excellence in psychology

Division of Clinical Psychology
Faculty of Perinatal Psychology

BEST PRACTICE GUIDANCE

Working therapeutically with parents and their infants during pregnancy and postpartum using remote delivery platforms

INTRODUCTION AND PURPOSE

The use of telehealth interventions, such as telephone and online audio-visual platforms, has increased across the health and social care system in recent years. There is a substantial evidence base demonstrating that remote and blended forms of delivering psychological interventions are as safe, effective, and acceptable as face-to-face treatment for a number of presenting problems, including depression, post-traumatic stress disorder (PTSD), social phobia and panic (Karyotaki et al. 2018a; Karyotaki et al. 2018b; Kuester et al. 2016; Lewis et al., 2018; Spek et al. 2007), across a range of treatment modalities, such as Cognitive Behavioural Therapy (Carlbring et al. 2018), Interpersonal Therapy (Donker et al. 2013), Acceptance and Commitment Therapy (Lappalainen et al. 2014), Psychodynamic Therapy (Johansson et al. 2017), Self-Compassion Focussed approaches (Kelman et al., 2018; Krieger et al. 2019); and parenting interventions (Sanders et al. 2012). Recently, clinical trials of transdiagnostic treatments and treatments for personality disorder delivered via the internet are also underway (Weisel et al. 2018; Zanarini et al. 2018). Studies of remote delivery of both adult mental health and parent-infant dyadic treatments with perinatal populations have similarly found it is an effective and acceptable delivery format (Danaher et al. 2013; Forsell et al. 2017; Kelman et al. 2018; Kersting et al. 2013; Milgrom et al. 2016; O'Mahen et al. 2014). Critically, there is evidence that remote delivery is as effective as face-to-face delivery formats (Carlbring et al. 2018) and that the working alliance between clients and psychologists is strong in both remote and face-to-face delivery formats (Preschl et al. 2011).

The Covid-19 pandemic has sharply accelerated the need to deliver psychological services remotely. This guidance addresses the practical and clinical challenges of working remotely with parents during pregnancy and the first two years post-birth. We have written this guidance to be inclusive of mothers, fathers, co-parents and other primary care-givers of infants/toddlers. We hope that this guidance supports clinicians to embrace and develop skills in delivering technologically-mediated psychological interventions. This guidance has been written for applied psychologists, and it is intended to be useful to other psychological practitioners and psychotherapists working in perinatal and parent-infant mental health services. Our aim is to help applied psychologists consider some of the unique issues of working with pregnant women and the primary care-givers of 0–2 year olds and it should complement local policies. Whilst there is a current focus on using online video platforms,

BEST PRACTICE GUIDANCE

"The interlocking of integrity and trust in caretaking relationships completes the cycle of generations and regenerates the sense of human community which trauma destroys."

Judith Herman, *Trauma and Recovery.*

Questions?