Introduction

Perinatal Child–Parent Psychotherapy (P-CPP) is an application to pregnancy and the perinatal period of Child–Parent Psychotherapy (CPP), a relationship-based, trauma-informed treatment for children ages birth–5 years and their caregivers that has the goal of healing trauma and preventing the intergenerational transmission of psychopathology (Lieberman, Ghosh Ippen, & Van Horn, 2015; Lieberman & Van Horn, 2008). P-CPP starts during pregnancy, with the goal of guiding parents-to-be toward greater self-understanding and a more loving capacity to provide safe and nurturing care for their baby. Although pregnancy and the first months of the baby's life are normal developmental transitions, this time is also one of enormous physical and emotional vulnerability for parents and baby. P-CPP aims to provide mothers and fathers with the support they need when their adverse life circumstances and their emotional and interpersonal difficulties interfere with their ability to give their baby the love, care, and protection needed to promote healthy development. This P-CPP implementation manual addresses the unique challenges and opportunities of pregnancy and the perinatal period, which call for specialized clinical expertise and a specific training focus on the psychological, interpersonal, and concrete life issues that emerge during this extended adult developmental stage.

Even in optimal conditions, pregnancy and the postnatal period elicit a wide range of emotions as mothers and fathers encounter and prepare for the joys, challenges, and responsibilities of parenthood. Creating safe intimacy with a new baby calls for the parent to relive, consciously or unconsciously, what it was like to *be* a baby. For women, the bodily sensations of feeling the fetus growing in the womb and later holding, touching, smelling, listening to, and gazing at the newborn baby can evoke states of profound bliss that escape verbal articulation. For men, multilayered emotional processes unfold as they anticipate

becoming a father, while also relating to the changes in the intimate partner's body, moods, and behavior during pregnancy.

The earliest, preverbal experiences of helplessness and total dependence on others may re-emerge for expectant parents in unrecognizable forms. Pride in becoming pregnant, feelings of completeness, longing for complete fusion with the baby, and anticipatory joy in meeting the baby may alternate with self-doubt, anxiety, fear of entrapment, and anger in response to the physical challenges of the perinatal period or when the fetus/baby does not conform to the parent's fantasies of an idealized, contented, and well-behaved infant. The body changes and emotional processes set in motion by the pregnancy also transform the romantic relationship between the partners, with far-reaching implications for each partner's perception of themselves and each other in the new interpersonal context of parenthood.

Like all developmental transitions, pregnancy and the perinatal period open up new possibilities for emotional growth that can foster the mental health of the parents-to-be as individuals, their self-confidence as parents, and their baby's healthy development. Also like other developmental transitions, this period presents a heightened risk of psychological disorganization. The risk of emotional disequilibrium increases exponentially when expectant parents grew up in conditions that exposed them to unmanageable fear and/or when they are facing adverse or traumatic present circumstances with limited adaptive coping skills. The profound affective impact of pregnancy often creates a readiness for introspection, momentum toward change, and desire for help that make many expectant parents more receptive to services such as psychoeducation and psychological treatment. The anticipation of nurturing a new life gives many parents the impetus to come to grips with their past and to acquire the internal resources to build safety in the present and prepare for a more rewarding future.

Psychotherapy during pregnancy has the overarching goal of psychological reorganization and a higher level of emotional integration, including consolidation of a new maternal and paternal identity. The relationship with the clinician can be reparative in nature, with the clinician offering a nurturing, holding space to contain anxiety, work through intrapsychic and interpersonal conflicts, and receive developmental guidance and emotional support while grappling with the internal and reality-based challenges presented by pregnancy and upcoming parenthood. In this therapeutic process, the expectant mother and father (individually and/or together depending on clinical considerations) can gain insight into their positive and negative attitudes and unconscious attributions to the baby, allowing them to experience the baby as a separate person rather than a transference object for

unresolved psychological conflicts (Fraiberg, 1980; Lieberman, 1983; Lieberman & Blos, 1980; Slade & Sadler, 2019). While becoming more attuned with the unborn baby, parents-to-be may also be more likely to change maladaptive behaviors to protect their own and their baby's health—for example, by improving nutritional habits, exercising, and/or discontinuing the use of harmful substances.

When treatment continues after the baby's birth, it can offer the parents opportunities to process the pregnancy and childbirth and to reflect on their emerging experiences as parents of this particular baby. A versatile therapeutic process promotes emotional growth while also building caregiving competencies that can translate into personal self-efficacy. Perinatal clinicians provide psychoeducation about babies' needs, helping the parents hone their caregiving skills through hands-on, individually tailored developmental guidance both in the moment and anticipating future developmental stages. The clinician can also provide parents with a safe interpersonal space to reflect on their emotional reactions, explore how their childhood experiences affect their adjustment to parenthood and their feelings for the baby, pursue the integration of positive and negative feelings, and modulate ambivalence in ways that summon love for the baby as a protective shield against anger and hate. Babies' urgent needs—as manifested, for example, in inconsolable crying or expectable biological dysregulations such as sleep disruptions in the first months of life—may act as triggers for the parents' reexperience of unresolved early conflicts or traumatic experiences. In the course of the treatment, the parents make use of the safe therapeutic space to identify and reflect on their emotional responses to the baby's signals, which become a concrete port of entry to help them examine how their own unmet emotional needs may continue to engulf the baby in negative perceptions and attitudes that interfere with attuned caregiving. For all these reasons, effective therapeutic intervention during and after pregnancy may help prevent the intergenerational transmission of psychopathology from parent to child.

This book provides guidelines that enable clinicians to implement P-CPP with fidelity to the conceptual frame and to the therapeutic modalities and strategies of the model. The book comprises five sections. Section I provides an overview of the theoretical contributions, scientific findings, and existing clinical interventions that frame pregnancy and the perinatal period as an extended developmental phase characterized by concrete biological and psychological manifestations that are profoundly affected by environmental circumstances and cultural meanings. Section II describes the P-CPP phases of treatment and therapeutic strategies and provides clinical examples that illustrate

their application. Section III features four full-length case examples that follow a family from the beginning to the end of treatment, with each case illustrating a specific set of adverse circumstances that endanger the parents' loving commitment to their baby. Section IV consists of brief clinical vignettes that highlight therapeutic approaches to some common clinical presentations. Section V provides fidelity items to help clinicians monitor the extent to which they are following P-CPP guidelines for treatment, including their affective responses to the family and possible countertransference reactions that may negatively affect treatment outcome by interfering with the therapeutic alliance or their effectiveness as clinicians. All the clinical illustrations and case presentations in this book have been substantially changed in ways that preserve the confidentiality of the families, including changes in the description of the parents and composite clinical examples.

Although this book is structured as a P-CPP implementation manual, we do not prescribe a standardized, step-by-step approach to treatment. Our core clinical values are rooted in a psychodynamic understanding of emotional processes and therapeutic effectiveness that prioritizes the clinician's responsiveness to the themes and emotional tone of the clinical moment. Like CPP, this extension to pregnancy and the perinatal period is informed by the conviction that transformational treatment is co-created by the clinician and the recipient(s) of treatment. Each parent and each baby present a broad range of psychological strengths and vulnerabilities that contribute in unique and unpredictable ways to the relationship between them. Clinicians need to rely on their clinical judgment and their level of comfort with a range of therapeutic strategies to appraise the domain of intervention that might be most promising for promoting positive change at any given moment. The intersubjective space that unfolds between the treatment participants and the clinician is the essential container for effective clinical interventions but cannot be dictated or predicted in advance. Although P-CPP places great value on a clear clinical formulation that informs the treatment plan, the salient clinical issue and the nature of the intersubjective space in the moment help the clinician choose which of the relevant clinical formulation themes to pursue. The same versatility applies to the choice of a specific therapeutic technique in the moment. These techniques may include, for example, concrete assistance, developmental guidance/psychoeducation, insight-oriented interpretation, cognitive-behavioral interventions, and mindfulness or body-based interventions, which are flexibly deployed depending on the clinician's appraisal of which approach to intervention holds the greatest mutative potential at any given moment.

Along with their freedom to use their clinical judgment in choosing when and how to intervene, P-CPP clinicians have the sometimes daunting responsibility of learning the different bodies of knowledge that comprise the fields of developmental psychopathology and psychotherapy. These areas of knowledge include, but are not limited to, the domains listed below:

- Expectable developmental processes through the lifespan, with a specific focus on pregnancy, labor and delivery, and parenting during the first year of life as transformational adult developmental stages.
- Normative developmental milestones and caregiving practices in infancy and early childhood.
- Infant/early childhood and adult psychopathology, with a specific focus on manifestations of psychopathology during pregnancy and the perinatal period.
- Impact of trauma on development and mental health, including the neurobiology of posttraumatic stress disorder (PTSD) and depression and the trauma triggers emerging during pregnancy and the perinatal period.
- Cultural diversity in childrearing practices and sensitivity to racial, ethnic, religious, gender, and sexual orientation diversity as they manifest during pregnancy and the perinatal period.
- The theory and practice of psychotherapy, with special attention to attachment and psychodynamic theories.
- The systems relevant to pregnancy and perinatal care, including primary care for parent and child, reproductive health, substance abuse and domestic violence resources, and the legal system when maltreatment may be involved.

Each one of these domains calls for commitment to ongoing learning. To paraphrase Freud, becoming a skilled clinician involves a "terminable and interminable" personal process as each of us encounters the infinite variability of human experience and endeavors to respond to suffering in humane and effective ways. We hope that this book will be a useful tool in meeting this goal.

Section I

Pregnancy and the Perinatal Period

Hope and Vicissitudes

This section provides a conceptual framework and literature review documenting the biological, psychological, and interpersonal processes involved in pregnancy and the perinatal period and the influence of parental environmental and cultural circumstances. It includes succinct comments making explicit connections between the research findings described and their clinical implications for the treatment and prevention of trauma. For the purposes of this manual, we define the perinatal period as encompassing the entire pregnancy, childbirth, the postpartum period, and the baby's first year of life. This section also presents brief descriptions of existing clinical interventions during the perinatal period, which provide a context for the extended description of Perinatal Child–Parent Psychotherapy (P-CPP) in the rest of the book.

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