

Ask the Expert

Alicia F. Lieberman

ZERO TO THREE Board Members share their expertise and insight regarding important issues affecting infants, toddlers, and their families.

MEET: Alicia F. Lieberman, PhD is the Irving B. Harris Endowed Chair in Infant Mental Health, professor and vice chair for Academic Affairs, University of California San Francisco Department of Psychiatry; and the director, Child Trauma Research Project, San Francisco General Hospital. Dr. Lieberman has made major contributions to the field's understanding of attachment, toddler development, the impact of violence and other traumatic stressors on young children, and cross-cultural perspectives on early development through her research, writing, training, and consultation. Her current research interests are in treatment outcomes on effectiveness of child-parent psychotherapy, and the impact of domestic violence and chronic traumatic stressors on early mental health, and on child development.



Domestic Violence During Pregnancy

Q: How does exposure to violence affect infants during the prenatal period?

A: Newborns are profoundly shaped not only by genetic and other biological influences but also by the context in which they grew as a fetus: both the intrauterine environment of their mother's body and the physical and social environment of their parents and community. When the pregnant woman's well-being is shattered by traumatic experiences, the consequences are harmful for both the woman and the fetus. Domestic violence can have health consequences as serious as those of medical conditions that are routinely screened for during pregnancy (e.g., gestational diabetes and pre-eclampsia), and may include maternal low weight gain, hemorrhage, infections, anemia, pre-delivery hospitalization, and Cesarean sections; for the baby, gestational exposure to domestic violence is associated with infant prematurity, low birth weight, excessive crying, feeding and sleeping problems, and susceptibility to infectious diseases.

Q: How do you intervene to support pregnant women who may be experiencing domestic violence?

A: Addressing maternal and child safety and well-being in domestic violence situations calls for coordination of services across health care providers. To address these needs, the Child Trauma Research Program (CTRP) at San Francisco General Hospital launched a model of collaboration linking trauma-trained infant mental health providers, the Ob-Gyn Women's Health Clinic, and the Department of Pediatrics. The way it works is as follows:

The social worker at the Women's Health Clinic systematically asks pregnant women coming for prenatal care about life adversities and about their frame of mind, probing for exposure to domestic violence or other traumatic stressors. When a woman reports experiencing stress or violence with her partner, the social worker gives her a brief description of CTRP mental health services and asks whether the CTRP clinician can meet her at the next prenatal care visit. If the mother agrees, the CTRP clinician meets the woman at the clinic to tell her about pregnancy as an important time to care for herself and provide a good beginning for her baby, and offers weekly counseling meetings through pregnancy, delivery, and until the baby is at least 6 months old. The treatment provided is labeled perinatal child-parent psychotherapy and represents an extension into pregnancy of child-parent psychotherapy (CPP), a trauma-focused treatment for children in the birth to 5 year age range that involves meeting with parent and child jointly and using play, caregiving routines, and spontaneous interactions as the basis to build safety and restore reciprocity.

Q: When and how should fathers be involved in treatment?

A: The first consideration is whether the mother wants her partner to be involved. Many mothers in violent relationships use treatment as a private opportunity to safely explore whether they want to remain in the relationship and how they want the relationship to change now that there is a baby at stake. It

is important to honor the mother's motivations and enable her to use the treatment as a tool to plan for a safer future for herself and her baby. The second consideration is safety for the mother, the baby, and the clinician if treatment is offered. Many of the fathers are described by the mothers as unpredictably violent; others stalk the mothers after the relationship ends. There are sometimes court orders restricting the father's access to the mother, the child, or both. Each one of these situations needs careful evaluation in the decision to extend fathers an invitation to treatment. We adopted five criteria for offering treatment to a violent father: (a) the mother wants to include the father in the treatment; (b) the father acknowledges that he engages in violent behavior; (c) he expresses the wish to change and makes a commitment to refrain from violence during the treatment; (d) he is willing to participate in an anger management program in tandem with starting treatment; and (e) he signs releases of information that enable the clinician to gain access to information about him from all relevant sources, including mental health providers, probation officers, child welfare workers, and the courts.

EDITOR'S NOTE: To learn more about Dr. Lieberman's approach to working with newborns and their mothers exposed to domestic violence, look for her article in the forthcoming May 2009 issue of the *Zero to Three Journal*.