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EDITOR'S NOTE:
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The survey can also be completed on-line at www.rch.org.au/ccch - follow the link to Resources and Publications / Child Health Newsletters.

POSTNATAL DEPRESSION AND MOTHER-INFANT INTERACTION

BECOMING A PARENT – A TIME OF VUNERABILITY

Parenthood is a major life transition. Although becoming a parent is a time of great joy and celebration, often the experience of motherhood is not what new mothers expected. Many women struggle with the countless changes and challenges associated with adjusting their lives to accommodate and nurture a new baby.

The following are some quotes from mothers who have attended our Infant Clinic at the Parent-Infant Research Institute (PIRI), Austin Health.

> *"There is a bit of a myth isn't there about motherhood, and how easy it is...? It is so natural to everybody isn't it? I mean as a woman, it's natural to be a mother...?"*

> *"We put pressure on ourselves. We assume we are perfect, we are women and we can do it all."*

The unexpected difficulties new parents face with the arrival of a baby have a significant impact on maternal and paternal well-being and mental health. Parents also often have feelings of guilt regarding the possible impact on their infant.

> *"I feel like such a failure as a parent."*

> *"My baby doesn't fit the answers!"*

Up to 30% of women experience mild depressive symptoms, adjustment problems and anxiety in the postnatal period. Difficulties in managing their baby's settling, crying, weight gain and breastfeeding are physical and emotional stressors and commonly lead to feelings of not coping and inadequate parenting.

POSTNATAL DEPRESSION – THE EXTENT OF THE PROBLEM

Postnatal depression is a devastating experience for new mothers. While a substantial number of women have difficulties adjusting, clinical depression affects around 10% of women both pre- and post-natally. Depression during the childbearing years presents with the same symptom profile as depression at other life stages and occurs across cultures.

MAJOR DEPRESSIVE DISORDER (MDD) DIAGNOSIS

In order to make the diagnosis of MDD (according to Diagnostic and Statistical Manual of Mental Disorders, 4th edition – DSM-IV), women need to experience the following symptoms in the two weeks prior:

- Depressed mood/irritability and/or
- Diminished interest in activities

Plus five of the following:

- Significant weight/appetite change
- Sleeping difficulties, insomnia or sleeping too much
- Fatigue
- Feelings of worthlessness/guilt
- Inability to think clearly or concentrate
- Recurrent thoughts of death and/or suicide
- Psychomotor agitation or retardation.

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IDENTIFYING 'AT RISK' WOMEN

Women rarely recognise the symptoms of depression in themselves and justify them as 'normal' for new mothers due to lack of sleep, the demands of a new baby or the transition to parenthood. They continue to try to cope, to look after their baby, partner, family and themselves.

> *"...when you've got a beautiful baby, you've got a beautiful home and partner, why would you be sad?"*

Given the high prevalence, lack of recognition of symptoms in the women themselves, and the serious far-reaching consequences of postnatal depression, efforts have been put into identifying risk factors so health professionals can identify those mothers most vulnerable.

Findings from the *beyondblue* National Postnatal Depression Program support midwives and Child and Family Health Nurses to universally and routinely screen mothers for depression and anxiety. Using a simple tool, the Edinburgh Postnatal Depression Scale (EPDS), screening has been found to be highly acceptable to women and health professionals. Women identified as 'probably depressed' on the screening tool can then be assessed more thoroughly and other risk factors taken into account. Appropriate next-steps can then be taken.

There is a strong belief among new mothers that Child and Family Health Nurses play a vital role in identifying and managing postnatal emotional distress. In a recent focus group study, (Bilszta, Ericksen, Buist, Milgrom, 2008) mothers felt that Child and Family Health Nurses were the most helpful health professional and that they should:

> *"See it (depression) coming, recognise it and take control..."*

> *"Offer the right option (for treatment) at the right time."*

THE EFFECT OF POSTNATAL DEPRESSION ON THE INFANT

There is evidence that postnatal depression can have profound ongoing effects on the baby as well as on the mother. The difficulties that arise in these relationships triggered by postnatal depression may persist even after the mother's symptoms have resolved.

IMPACT ON MOTHER-INFANT INTERACTION

From birth, mothers and infants engage in face-to-face interaction that lay down the foundation for the infant's social development. From observation, we can identify the characteristics of 'good enough' interactions, which are rhythmic with escalating cycles of engagement and disengagement.

Mothers build positive interactions with their infants through:

- Eye contact
- Physical responsiveness
- Empathy
- Reflecting what the infant might be feeling
- Sensitivity through immediate and appropriate responses to infant cues
- Mother's response being paced to her infant's cues
- Emotional engagement
- Joyful emotional interplay
- An environment that creates the expectancy for interaction
- Balancing stimulation with soothing and quieting interaction.

There is now substantial evidence that many postnatally depressed mothers have difficulty interacting with their infants.

Risk factors for postnatal depression include:

- Antenatal depression and anxiety
- Past history of depression
- Family history of depression
- Lack of social support from partner, mother
- Multiple stressful life events
- Negative cognitive style
- Low self esteem
- Low income
- Young maternal age
- Few years of education
- History of miscarriage and termination
- History of childhood abuse.

Depressed mothers may:

- Gaze and rock their infants less
- Are less active and decisive
- Have less well-timed responsiveness to their infants' demands
- Demonstrate less warm acceptance of their infant
- Lack energy and motivation
- Be irritable and/or be intrusive with their infants
- Misread the infants' cues
- Be emotionally 'flat'
- Be disengaged.

The symptoms of depression such as 'flat affect' make it difficult for depressed women to engage in a warm, nurturing mother-infant interaction, despite their genuine efforts to be the best mother they can. Depressed mothers report feeling less attached to their infants, finding their infants more demanding, and having diminished feelings of parenting competence. Up to 70% of depressed women have these difficulties.

It needs to be noted that mother-infant interactions following depression differ; some mothers may be withdrawn, others may be intrusive, while others may continue to find ways to interact optimally with their infants despite their depression.

The way the mother's partner or other close people interact with the infant will also influence attachment and child development. A father's attachment to their infant can buffer the effects of maternal depression and is key to improving infant well-being. However, to avoid further undermining of the mother's feelings of competence, it is important that this support be given in a sensitive way.

EFFECTS ON INFANTS' BEHAVIOUR

Infants are very sensitive to the quality of their interpersonal environment when it is disrupted experimentally even in brief and mild ways. It is not surprising that infants of depressed mothers have been described as more drowsy, distressed and/or fussy, look at their mothers less and tend to engage in more self-directed activity. Some infants show avoidance and withdrawn behaviour, whereas others show more protest behaviour. Increased emotional and behavioural disturbances such as problems with sleeping, eating, crying and separation have also been reported.

IMPACT ON ATTACHMENT AND LATER CHILD DEVELOPMENT

Appropriate maternal responsiveness leads to a secure attachment relationship between an infant and his/her mother. This primary attachment relationship helps form a child's sense of 'self' and forms the base from which children explore themselves, others and the world. Securely attached infants are more curious, flexible and socially competent, and can express anger, hurt, jealousy and resentment, confident of a sensitive response from their mother. The *insecurely* attached child may avoid closeness (avoidant) or may be highly anxious, demanding, crying and clinging (ambivalent). Insecurely attached children lack confidence that someone will 'be there' for them. Mothers may be dismissive or overreact when their child is needy as a result of being unable to handle her own negative feelings.

There is growing literature on the association of maternal depression and compromised later cognitive, emotional and social development in children, possibly resulting from a negative mother-infant interaction and poor quality of attachment.

DOES TREATING MATERNAL DEPRESSION IMPROVE THE MOTHER-INFANT INTERACTION?

Recent studies on treatment targeting maternal depression only failed to find substantial improvements in the quality of the mother-infant interaction, irrespective of the treatment modality: counselling, psychodynamic therapy or cognitive behavioural therapy.

A PIRI study showed that maternal mood improved following a 12 week cognitive behavioural therapy program. However, the relationship difficulties between mother and infant often persist. **It appears that when interactions develop poorly, there is a risk of an ongoing vicious cycle.** Maternal 'flat affect' and unresponsiveness results in a less interactive engaged infant who heightens maternal feelings of failure and the cycle continues. However, PIRI's specialised mother-infant programs have shown that the relationship can recover with appropriate support.

DIFFERENT WAYS TO SUPPORT MOTHER-INFANT ATTACHMENT

1. Interventions targeting a **parent's internal working model** of parenting aim to give insight into the parent's representations of the child through discussion of early family relationships, current close relationships and the connections between these. Parents are helped to understand that communication strategies learned in the past can either facilitate or undermine current relationships.
2. **Parenting behaviour** can be addressed directly. Attachment theory highlights the need to interpret the infant's cues and respond appropriately. Parents need to be supported in learning about their infant's behaviour and how to provide responsive and consistent care.
3. The **therapeutic relationship** formed between the mother and the therapist can be regarded as a corrective attachment experience for the mother. The therapist becomes a secure base for the parent, modelling understanding, support and encouragement for the parent. The parent is then more able to test new parenting behaviours.

MANAGEMENT PLAN FOR POSTNATAL DEPRESSION

A management plan for postnatal families should include the following:

- Always consider depression may be present and ask about it or use the EPDS. Early recognition and diagnosis minimise longer term consequences for mother, infant and partner.
- Think about the mother, the infant, the partner and other children. Paternal depression is correlated to maternal depression; ask how he is coping.
- Observe the mother interacting with her baby and how she responds to and interprets her behaviour. Does she understand her baby's needs? Is she able to soothe her baby when needed? Do they have good eye contact?
- Discuss with the woman, her partner and family what support is available and what would be helpful. Enlist family support.
- Develop a treatment plan which may focus on maternal symptoms (see www.beyondblue.org.au), mother-infant interaction, partner relationship, partner's mental health, specific baby management, parenting, support or risk management.
- Refer for specialist intervention where required, general practitioner, psychiatrist, psychologist, Mother-Baby unit, Crisis Assessment and Treatment Team (CATT), or other State/Territory-specific services.

Most importantly, if depression is suspected, devise a plan and give emergency contact numbers. Follow up and support them to take up the help offered.

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PIRI has developed the Parent and Baby Wellbeing program (sponsored by HBA) that includes a range of support services for parents with young babies. These services are fully covered for HBA members with hospital cover (Victoria only).

For more information, including a **case study** and a complete list of **references** for this article, please visit www.rch.org.au/ccch (click on Publications and Resources and then click Child Health newsletters).

REFLECTION QUESTIONS

1) *As part of your routine practice with new mothers, do you apply the Edinburgh Postnatal Depression Scale? Do you feel confident in its application?*
2) *A mother discloses at her baby's 3 month check, that she is experiencing feelings of self-harm. What action do you take?*
3) *How well do you know your local mental health service network? Have you developed a list of key contacts?*

TEENAGE PARENTS

OVERVIEW

Teenage pregnancy is considered to be one of the most important adolescent health problems in Western society. It is associated with a high economic cost involving both direct monetary expenditure for public assistance for welfare and child health care as well as negative societal outcomes in terms of child abuse, neglect and poverty (Quinlivan, 2004). Australia now has one of the highest adolescent fertility rates in the world.

Teenage mothers may experience a number of adverse outcomes associated with teenage pregnancy including failure to complete schooling, inability to find a job, and increased risk of poor health (Quinlivan, 2004; Social Exclusion Unit, 1999).

There is now considerable evidence that many teenagers idealise pregnancy and parenthood and regard it with high expectations. A significant proportion of adolescent pregnancies result as a consequence of positive, idealised attitudes to pregnancy, parenthood and personal change rather than by accident or negative attitudes to contraception (Condon et al., 2001).

The father's role is not often considered; however research has shown that up to 60% of fathers remain at least partially engaged at 6 months post partum. (Quinlivan, 2004; Social Exclusion Unit, 1999).

SUPPORT FOR TEENAGE PARENTS

- **Antenatal services**

Specialised teenage antenatal clinics can introduce the couple to parenting skills. Antenatal education can focus beyond the birth towards creating a safe home environment and parenting strategies for both mother and father. There is evidence that these services result in improved pregnancy outcomes and reduce the rate of preterm delivery (Nassar et al. 2003; Olds et al., 2002). The teenage parents with a preterm baby face the additional demands of a preterm infant in a setting when management of a term infant is hard enough. Issues of transportation to medical appointments become practical barriers to care when both parents lack a driver's licence, or they cannot afford a car and petrol.

In many rural areas, teenagers do not attend antenatal care as they cannot afford gap payments, and in some areas local hospitals no longer provide a free antenatal clinic service. Furthermore, funding cuts have seen antenatal social work services cut and they are now rare. The failure to involve the teenage couple in antenatal planning means that issues that could have been addressed in a timely manner are left as emergencies at delivery. This increases the chances of failure and may result in formal notification to child protection authorities.

Some teenage parents may be able to receive practical assistance and postnatal support through volunteer and not for profit programs. However continuity of care remains a challenge as many non-government organisations are dependent upon the sometimes unpredictable policy directions and funding cycles of all levels of government.

- **Sustained home visitation by nurses**

Research suggests that home visitation is a cost-effective intervention and can enhance parenting skills, reduce child abuse and neglect, and improve maternal life course. Successful home visitation programs are capable of engaging all care givers, and can focus on the couple.

An Australian randomised trial evaluated the effectiveness of nurse-midwives who met the teenage mother in the antenatal period and performed home visits. The visits were associated with a reduction in the pooled adverse effects of death, non-accidental injury, and care and protection notifications from 13% to 3% and improvements in knowledge and use of contraceptives (Stevens-Simon et al., 2001).

Evidence demonstrates that nurses are more effective in service delivery than paraprofessionals in achieving improved outcomes for new families (Olds et al., 2002; Stevens-Simon et al., 2001). Nurses are better able to engage new mothers than employed paraprofessionals. Other studies have likewise observed limited or no efficacy of employed paraprofessional home visitation.

The Australian Government has recently committed to provide sustained home visitation services using nurses to all Aboriginal and Torres Strait Islander

families. As a disproportional amount of these parents fall into the teenage cohort, this will play an important role in service delivery.

- **Mothers, fathers and couples groups**

New mothers' and fathers' groups, other community based group activities, peer support workers and intensive educational interventions to encourage return to schooling may be useful. Evaluation of these programs needs to occur so resources can be put into effective services. There is also poor evidence for the efficacy of services that engage both parents and fathers in particular. Many services continue to experience difficulties in engaging teenage fathers.

- **Practical help**

Practical help is effective and appreciated by teenage parents. Practical help includes assisting to find stable accommodation, furniture, advice on food, and access to free or cheap clothing and baby equipment, as well as support in times of crisis.

OTHER ISSUES

- **Domestic violence**

A major concern in the setting of a teenage pregnancy is domestic violence (Quinlivan, 2004; Social Exclusion Unit, 1999; Quinlivan et al., 2004). In dealing with teenage parents it is important to screen for violence in the current relationship and any past relationships. The father of the baby may also report a violent family background and this may impact on his behaviour and actions as a father.

- **Housing uncertainty**

This is a common issue for teenage parents. In many cases, the single teenage mother can earn a higher priority rating for state housing than the teenage family. This places couples who remain together in a difficult situation. Private housing is usually too expensive or located far from services such as public transport or medical care.

- **The second baby**

Preventing a second teenage pregnancy is an important outcome for teenage parents, as it is often the subsequent pregnancy that commits the family to a life dependency on welfare (Stevens-Simon et al., 2001; Furstenberg et al. 1989).

- **Return to education**

Finally, strategies to assist with a return to education are vital, as ultimately what will break the cycle of inter-generational poverty is education and employment. Current strategies are yet to be evaluated to help guide care givers in their implementation.

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A complete list of **references** for this article and an overview of Tasmania's **c u @ home**, a teenage mothers' home visiting program, is available from www.rch.org.au/ccch (click on Resources and Publications, then Child Health newsletters).

REFLECTION QUESTIONS

1) *Do you attempt to engage teenage mothers into your child and family health service antenatally?*

2) *A young mother presents with her six week old baby for a regular visit. She raises issues of partner violence at home. What implications does this have for your practice in relation to:*
   - *The safety of the mother?*
   - *The safety of the child?*

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