

Parallel Processes-Relationships Matter: A Key Concept in Infant and Early Childhood Mental Health Approaches



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September 26, 2013



Relationships are the Cornerstone of Wellness and Healing



Parenting Relationships Require a Present and a Future Commitment..



Who we are develops in
interaction with our loved ones
during infancy early childhood



Feeling “seen and held” Relationships are central to Development



Plasticity-The Good and the Bad News

The brain's ability to change as a result of experience.

Relationships are a series of



The Bad News: Babies Can Suffer in Relationships and the Impact can Last..



THE BRAIN IS A SOCIAL ORGAN

- ✱ The structure and function of the brain is to engage with other people, other brains, in the shaping of its development (including moral) over time and in shaping its activity in the present.
- ✱ Mirror Neurons and the capacity to develop empathy and insight = MINDSIGHT

Every child's birthright is joy, delight, and opportunities to learn embedded in secure relationships



Early Relationships and Emotion Regulation



- Experience of positive emotion helps infants to organize their experience
- Infant-caregiver face-to-face interactions help baby learn to regulate emotions particularly in the context of face-to-face interactions

Cole, Michel & Teti, 1994

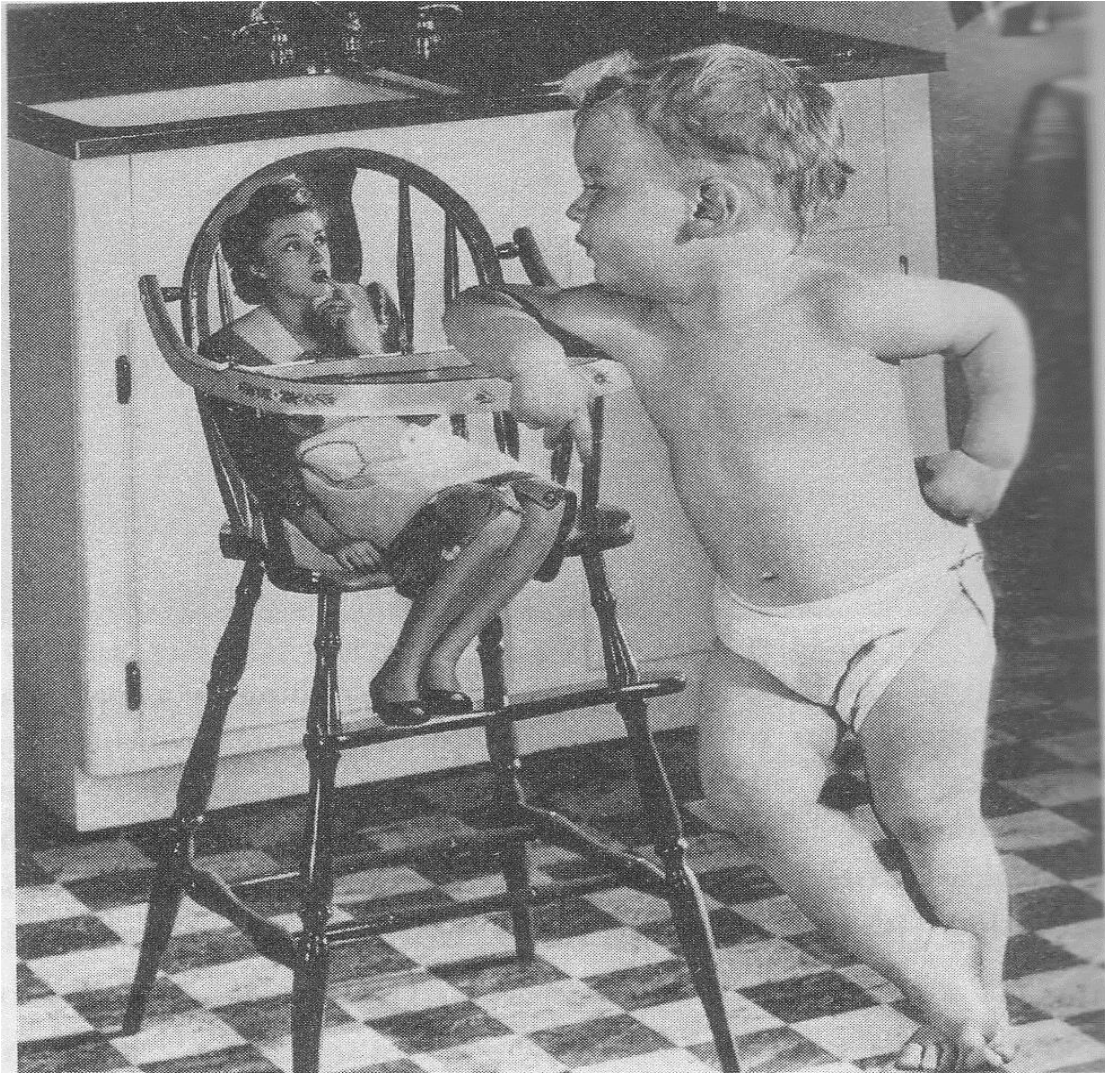
Learning about emotions



Affective Transmissions in Mutual Gaze Transactions

- Attunement
- Reflecting internal state
- Moment-to-moment matching of affective direction
- Important for joint attention
- Precursors of attachment
- Precursors to moral development

Relationships with Children can be Challenging to Parents



Maternal Depression and Parenting

- Impact on ability to foster healthy relationships
- Impact varies by timing, severity, and length

(Knitzer et al, 2008)



Bi-Directional Effects in Depressed Mother-Infant Interactions



Mother's depressed mood may induce a depressed state in the infant

Bi-Directional Effects in Depressed Mother-Infant Interactions (Cont' d.)



- Infant's subsequent distress and unresponsiveness are likely to maintain and perhaps increase the severity of the mother's depression
- Lack of infant responsiveness may validate the mother's depressive self-schemata and her experience of herself in relationships

Postpartum Spectrum

Postpartum Blues

Postpartum Depression

Postpartum Psychosis

Severity



Postpartum Blues

- Prevalence 50-80% of new mothers
- Onset Within 10 days
- Peak 3-5 days after delivery
- Symptoms Tearfulness, lability, fatigue
- Impact Usually transient and does
 - not interfere with caregiving
- Context Present in all cultures studied;
 - not related to psychiatric history or environmental stress

Risk Factors for Postpartum Depression Across Cultures

- Past episode of depression or anxiety disorder
- Family history of depression or other mood disorder
- Ambivalence about or unplanned pregnancy
- Pronounced fear of childbirth
- Low SES
- Low social support or marital satisfaction
- Daily chronic stressors
- Significant loss or life stress in the last year
- Infant temperament; health/obstetric problems; multiples

Postpartum Depression

- Prevalence 10-15%; 1 out of every 8 mothers
Up to 50% of new mothers and 6% of fathers living in poverty
- Onset Within 4 weeks of birth (DSM-IV)
- Peaks 3-6 months after delivery
- Symptoms Similar to depression
- Impact Capacity to care for child depends on severity and co-occurring risks
- Without treatment, 30-70% of women continue to have depression after one year.

Major Depression: Key Symptoms

- At least one of the following (by self-report or others' observations) for 2 weeks
 - **Depressed mood** most of the day, nearly every day
 - Markedly **diminished interest** or pleasure in all, or almost all, activities most of the day, nearly every day

(DSM-IV-TR, 2000)

Major Depression: Associated Symptoms

- Four or more of the following:
 - Changes in weight and appetite
 - Insomnia or hypersomnia
 - Psychomotor agitation or retardation
 - Fatigue or loss of energy
 - Feeling worthless or guilty
 - Impaired concentration, indecisiveness
 - Thoughts of death

Clinical Features of Postpartum Depression

- Depressed, despondent and/or emotionally numb
- Sleep disturbance, fatigue, irritability
- Loss of appetite
- Poor concentration
- Feelings of inadequacy
- Ego-dystonic thoughts of harming the baby

(Miller, 2002)

Postpartum Depression and Anxiety

- Psychiatric problems co-occur; 79% of persons diagnosed have more than one disorder.
- “Gold standard” for identifying psychological distress in new mothers is whether women meet diagnostic criteria for depression.
- Postpartum anxiety, particularly panic and related fears/obsessions about the care and safety of the baby, may be more distressing for women than depressed mood.
- In a community sample receiving a preventive intervention to promote postpartum well-being, nearly equivalent rates of depression only and co-occurring depression and anxiety were found among first-time mothers. Kessler et al., 1994; Matthey et al., 2003

Low income and ethnic minority women are least likely to use mental health services

- Difficulty recognizing depression; symptoms seen as naturally occurring due to life circumstances (poverty/abuse)
- Believe they are still functioning and do not have the type of depression that needs medical help
- Fear mental health treatment will result in judgment that they are inadequate
- Value child and understand impact on child but fear losing child
- Concerned about medication as treatment

- Issacs, 2004

Postpartum Psychosis

- Prevalence: 1/1000 births
- Onset: May occur as early as 1 day after delivery through first year; usually first 3 weeks
- Symptoms: Agitation, racing thoughts, rapid speech, insomnia, delusions, hallucinations, paranoia, thoughts of suicide and infanticide
- Impact: Unable to care for child

Postpartum Psychosis (Cont' d.)

- Often serious and requires immediate medical attention
- May necessitate involuntary admission to hospital
- Risk of infanticide or suicide are high

Parent Infant Interaction: Still Face Paradigm



- By 3 months, infants actively engaged in monitoring how people relate to them
- How they feel and what they will do next

Impact on Family Relationships

- Altered roles within the couple/parenting partners
 - Joy of fatherhood replaced with despair, anger, worry, guilt
 - Creates emotional distance
 - Impairs communication
- Altered roles within the extended family
- Establishing alternate caregiver patterns that become difficult to change later
- Men are often affected emotionally
- Maternal depression has been shown to be the strongest predictor of paternal depression during the postpartum period

Born et al., 2004

Maternal Functioning

- Decreased involvement with
 - Physical care, child's play, looking at book, talking
 - Breastfeeding
 - Safety practices
 - Less car seat use, fewer outlet covers & smoke detectors; less back to sleep (mixed results)
 - Preventive health measures
 - Fewer well-baby visits and vaccinations
 - Managing chronic health conditions (more ER visits)
 - More corporal punishment in first year

Parenting Behaviors

- Irritability and self-preoccupation— inability to meet infant's normal needs for attention
- Lack of affection towards infant and resulting feelings of guilt and/or inadequacy
- Anxiety about doing psychological or physical harm towards infant (Weissman et al., 1979)

Quality of Mother-Infant Interaction

- In the still face paradigm, infants of depressed mothers showed:
 - less interest
 - more anger and sadness
 - greater tendency to fuss
- Depressed mothers, more than non-depressed mothers,
 - perceived interactions more negatively
 - showed more anger

Possible manifestations of postpartum depression in parenting

- Mothers:

- Fewer overall interactions (disengagement)
- More matching of negative states than positive
- More anger
- Less positive interactions (affective flatness, irritability)
- Less consistency
- Decreased mutual cueing

- Infants

- Fewer positive/ more negative facial expressions
- Fewer vocalizations
- More fussy and tense
- More gaze aversion (over time, infant learns to look away)



Impact on Children

- In response to negative early experiences, infants may withdraw from daily activities and eventually avoids any kind of interaction with caregivers
- May be more irritable, difficult to soothe, and less “happy”
- Learn from these patterns and perceive that only negative strategies, such as fussy or crying will elicit a response

Maternal Depression and Child Development at 3 Years of Age

- Women with chronic depressive symptoms were the least sensitive when observed playing with their children from infancy through 36 months
- Children did more poorly on measures of cognitive-linguistic functioning, cooperation and had more behavior problems at 36 months
- Maternal sensitivity moderated outcomes

Maternal Depression and Child Development at 3-5 Years of Age

- Lower IQ

Boys age 3 years, 10 months whose mothers were depressed during the first year scored 1 standard deviation lower on IQ tests than boys whose mothers were not depressed, etc.

- Hyperactivity/Distractibility

Maternal depression and behavior, and infant temperament and attentional capacities across the first year of life predicted child hyperactivity/ distractibility at 4 1/2 years.

- School Problems

Postnatal and recent maternal depression were associated with teacher reports of increased disturbance in school at 5 years old, especially among low SES boys.

Greatest Impact of Maternal Depression on Child Development

- Mother's depression is chronic & severe (Teti, et al., 1995)
- Infant is male (Tronick and Weinberg, 2000)
- Mother is living in poverty (Beeghly, et al., 2003)
- When few risks exist, the impact may be small or non existent (Campbell and Cohn, 1997)

Maternal Depression and Child Maltreatment

- Some studies show 2-3 fold increased risk of physical abuse, psychological aggression, and medical neglect (Chaffin, Kelleher, & Hollenberg, 1996; Windham et al, 1987; Weissman, et al., 1987)
- Mothers with depression and history of extensive childhood trauma reported more neglect (Banyard, Williams, Siegel, 2003)
- Recent longitudinal study showed onset of maternal depression associated with 2.3 increase in psychological aggression, but not in physical assault or neglect (Canron, et al., 2009)
- Increase in work time and addition of intimate partner to home decreased aggression; exposure to partner violence increased physical assault and neglect; increased child behavior problems increased psychological aggression and physical assault (Canron, et al., 2009)

Perinatal Screening Tools: Conversation Starters



Opportunities for Screening

- *OB/GYN 6 week follow-up visit*
- Symptoms of depression often occur in the 1st 4-8 weeks postpartum; If undiagnosed and untreated, PPD can last from 3-14 months
- *Pediatric Well-Baby visits*
- Probably the best opportunity to wonder with the mother about her own well-being and availability of social support and conduct formal screening
- *WIC Clinic visits*

Home Visitation Programs

- During pregnancy
 - 1st prenatal visit and/or 3rd trimester
- 6 weeks & 3 months postpartum
 - Most cases of PPD begin within first 3 months postpartum (O' Hara, 1997)
- Any visit during first year

Introducing Screens

- Normalize screening (ideally a universal practice)
- Assure privacy and confidentiality
- Opportunity/Tool for “checking in” with yourself
 - Focus of attention often on caring for baby/other children, mothers may not have time to stop and reflect on how they are doing
- Helps us track your needs over time to make sure they are getting met

Methods of Screening

- Informal/Unstructured/Clinical Impression
 - “Is this mother acting depressed?”
 - “How well is this mother functioning?”
 - Effective in detecting only the women with the most chronic and severe symptoms
- Better: Focused Questions
 - “During the last 2 weeks...
 - have you been bothered by feeling down, depressed or hopeless?”
 - have you been bothered by having little interest or pleasure in activities?”
- Best: Brief Screening Questionnaires
 - Integrated into ongoing practice

Ways to Discuss Screening Results

- Positive score:
“Your score indicates that you may be depressed. How does that fit with what you’ve been experiencing?”
Making a wellness plan: “Can we talk about some ways to help you feel better?”
- Close to cut off score
“Your score isn’t in the range for likely clinical depression, but it sounds like you’re struggling right now. Let’s talk about what kinds of support would feel helpful.”

Referral

- Ideally referral should be made to a mental health professional with experience in evaluation of perinatal mood disorders or a health professional qualified to assess for depression
- Important for the woman to have a comprehensive psychological/psychiatric evaluation
- Suicidality and thoughts of harming her infant should be carefully assessed

Limitations of Screening: Need for Systems Collaboration

- “Screening for Perinatal Depression improves the detection of mood disorders, but not necessarily patient outcomes unless there is collaboration between primary health providers and mental health providers, and systems of support/case management that ensures treatment follow-up and compliance”
(Gjerdingen, DK., et al, 2007)

Research on Postpartum Depression and Infant Development

- Maternal remission of depression within 3 months associated with decreases in the mood symptoms of their children at 7 – 17 years of age

(Weissman, MM., et al., 2006)



Supportive Interventions



Supportive Interventions (Cont' d.)

- Women may be feeling overwhelmed and sensitive to perceived criticism in their new role
- Simple and non-threatening interventions can be an important part of healing.

Supportive Listening

- Listen with empathy and understanding
- Don't assume mother has others in her life to provide this type of emotional support
- Don't underestimate the healing power of supportive listening & empathy for both mother and infant

Activate a Circle of Support



Creation of a Community Holding Environment

A “way of being” that involves careful listening and thoughtful waiting, allowing the participants to discover solutions and explore concepts and perceptions without interruption.

Do unto others as you would have others do unto others

Community members who are “held” in this way are more likely able to hold and nurture the complexity of parent-child relationships.

What is "Reflective" Function?

The Parallel Process?

The capacity to reflect on what is occurring and to consider multiple possibilities is an essential skill for staff working with families and children. Important parallels with this skill are found in childrearing.

Reflective Function

Transmission of Reflective Functioning - Parallel Process

- Related to secure attachment
- Makes it possible for a parent to accurately read a child's intentions and feelings and to respond sensitively
- Staff who are reflective help parents expand reflective capacity
- Supervisors who are reflective help staff expand reflective capacity

Reflective Function (Cont' d.)

- Stepping back from the immediate experience to sort through thoughts and feelings about what one is observing and doing with children and families
- Hitting the pause button
- Refueling
- Regulation

What is the Reflective Supervision Relationship?

Reflective Supervision is a respectful and reciprocal relationship for learning that becomes a model for relating to a family and to their child.

(Shahmoon Shanok, Gilkerson et al 1995, p.9)

Reflective Supervision is a Relationship

In which strengths are emphasized and vulnerabilities are partnered.

Reflective Supervision:

- is based on shared power
- builds shared understanding of philosophy and practice
- diminishes scale

- Reflective Supervision:
- supports ethical practice
- reciprocity supports initiative and effective engaged practice
- develops the art of remembering

Reflective Supervision:

- creates and hones self-knowledge
- supports inter-cultural competence
- amplifies calm and responsivity
- encourages experimentation and critical thinking