Infant Parent Relationships: Strength-based Early Intervention Approaches

Foundations of Infant Mental Health
Central California Children's Institute
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Defining the Word Relationship

- Introduce Yourself
- In your group have a brief discussion about the word **Relationship**
- Please write a sentence defining the word **Relationship**

Relationship

An affectionate bond between
two individuals that endures through
space and serves to join
them emotionally.

John Bowlby, 1969

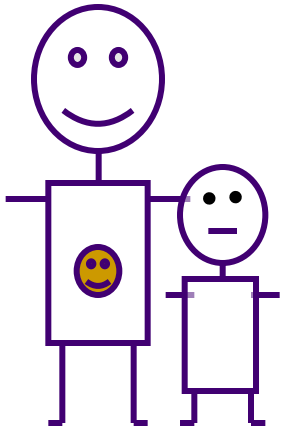
Transactional Model

Need to consider interaction and goodness of fit between the following characteristics

- Child's characteristics
- Parent's characteristics
- Environmental characteristics

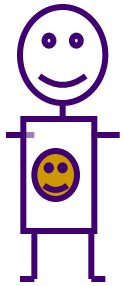
Developing Expectations about Relationships

Parent provides



Child receives:

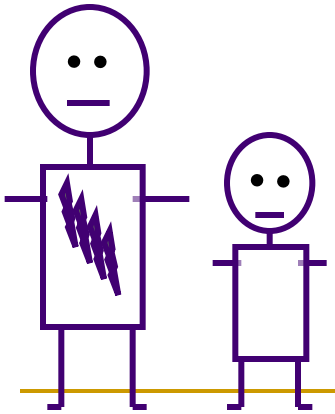
- Mirroring
- Protection
- Attunement
- Safety
- Eye contact responsiveness to cues



"Well-met 3-4 year old needs"

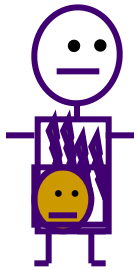
- **Empathy**
- **Regulate themselves**
- **Positive expectations of others**

Parent provides



Child receives:

- Lack of consistency
- Confusing emotional responses
- Abuse
- Neglect



"Unmet 3-4 year old needs"

- **Difficulty with:**
- **Self-soothing**
- **Empathizing**
- **Controlling impulses**
- **Negative expectations of others**

Parental Characteristics

- Acceptance vs Rejection
- Accessibility vs Ignoring/Neglecting
- Cooperation vs Interference
- Sensitivity vs Insensitivity to babies cues

Mary Ainsworth, 1972

Two Things I Know for Sure…

I am right doesn't always = what is true

and…

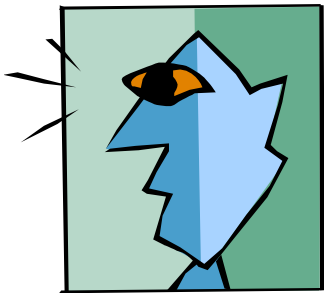
Reflective practice encourages us to shift from a place of certainty to one of curiosity and wonderment

Gathering Information

- What did you observe?
- How did it make you feel?
- What are the parent's strengths?

Which is it?

- Observation



- Assumption or Hypothesis

Video Observation

- Parent Playing with Baby
- Home Visitor Working with Family

Key Points

- Recognizing our own knowledge, beliefs, and biases increases our effectiveness as early interventionist
- Check out our assumptions before acting upon them

Objectives

- Definition, prevalence, symptoms, and risk
- Impact on maternal functioning and mother-infant/child and family relationships
- Prevention, screening and treatment

Postpartum Spectrum

Severity

Postpartum Blues

Postpartum Depression

Postpartum Psychosis

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

Postpartum Blues:

Symptoms

"Not feeling like myself"

- Tearfulness
- Irritability
- Mood swings
- Nervousness
- Feelings of vulnerability
- Loss of appetite
- Trouble sleeping
- Hyperactivity
- Lack of confidence
- Feeling overwhelmed

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: 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 Poverty

- Poverty is a key risk factor for the development of depression regardless of ethnicity
  - Low income women are disproportionately affected as depression is often embedded in life circumstances: poverty, lack of social supports and networks, substance abuse, intimate partner violence, childhood abuse, and stress linked to a life of hardships
- Low income mothers of young children, pregnant and parenting teens report depressive symptoms in the 40 – 60 % range

(Knitzer, et al, 2008)

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

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

Perinatal Screening Tools: Conversation Starters

Why Screening is Important

- Up to 50% of women with postpartum depression are missed by primary care physicians when screening instruments are not used. (Gale & Harlow, 2003; Steiner, 2002; Cooper& Murray, 1998)

- Why are so many women missed?
  -Stigma
  - Minimize symptoms or attribute to average demands of being a new mom
  - Anxiety may be the prominent symptom

Opportunities for Screening

Prenatal Screening:

- 23% of women with PPD had symptoms that began in pregnancy
- Depressed mood in pregnancy has been associated with poor attendance to prenatal visits, substance abuse, low birth weight and pre-term delivery

Opportunities for Screening

Hospital Post Delivery Screening:

- Too early to make a diagnosis of PPD
- Can provide an opportunity to screen for risk factors associated with PPD (low SES, lack of social support, personal or family history of depression, stressful life events and refer to public health nursing or home visiting program for support and monitoring

- Clark, 2010 University of Wisconsin

Screening for Peripartum Depression: Edinburgh Postnatal Depression Scale (EPDS)

- 10 item self-report questionnaire
- Advantages:
  - Free and quick
  - Easy to score
  - Specifically designed for peripartum use
  - Well validated during pregnancy and postpartum
  - Cross-culturally validated; available in over 20 languages
- Disadvantages:
  - Not linked with DSM-IV diagnostic criteria
  - Can not be used for assessment or treatment tracking

(Cox & Holden 2003; Watkins et al., 1987)

Edinburgh Postnatal Depression Scale (EPDS)

Taken from the British Journal of Psychiatry
June, 1987, Vol. 150 by J.L. Cox, J.M. Holden, R. Sagovsky

Circle the number or each statement, which best describes how often you felt or behaved this way *in the past 7 days…*

I have been able to laugh and see the funny side of things. ❶ As much as I always could ❶ Not quite so much now ❷ Definitely not so much now ❸ Not at all	Things have been getting on top of me. ❸Yes, most of the time I have not been able to cope at all ❷Yes, sometimes I have not been coping as well as usual ❶No, most of the time I have coped quite well ❶No, I have been coping as well as ever	
I have looked forward with enjoyment to things. ❶ As much as I ever did ❶ Rather less than I used to ❷ Definitely less than I used to ❸ Hardly at all	I have felt so unhappy that I have had difficulty sleeping. ❸ Yes, most of the time ❷ Yes, sometimes ❶ Not very often ❶ No, not at all	
I have blamed myself unnecessarily when things went wrong. ❶ No not at all ❶ Hardly ever ❷ Yes, sometimes ❸ Yes, very often	I have felt sad and miserable. ❸ Yes, most of the time ❷ Yes, quite often ❶ Not very often ❶ No, not at all	
I have been anxious or worried for no good reason. ❸ Yes, quite a lot ❷ Yes, sometimes ❶ No, not much ❶ No, not at all	I have been so unhappy that I have been crying ❸ Yes, most of the time ❷ Yes, quite often ❶ Only occasionally ❶ No, never	
I felt scared or panicky for no very good reason. ❸ Yes, quite a lot ❷ Yes, sometimes ❶ No, not much ❶ No, not at all	The thought of harming myself has occurred to me. ❸ Yes, quite often ❷ Sometimes ❶ Hardly ❶ Never	
Column Total = _____	Column Total = _____	Total = _____

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."

Clark, 2010 University of Wisconsin; N.. Lively, UIC Women's Mental Health Project

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)

Supportive Interventions

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

- Clark, 2010 University of Wisconsin

Normalize

- Normalize negative experiences postpartum
  - Women suffering from PPD report reassurance that others have similar thoughts/experiences as being the most helpful (McIntosh, 1993)
- Alleviate distress by helping to establish realistic expectations of motherhood (during pregnancy and after)
  - Ex. Making the mistake of believing things should be the same as before the baby was born; Not realizing the impact of the newborn needing 24/7 care on their ability to “get things done”

Spirituality

- Honor and encourage the use of reflection or prayer as a calming time for your clients and yourself
- Spiritual community may be an important source of support

Take Breaks

- Encourage women to do something they like to do, not something they have to do
- Encourage them to schedule brief breaks at home just like at a job – it can be refreshing and allow them to come back to parenting in a more reflective, less reactive frame of mind

Clark, 2010 University of Wisconsin

Sleep

- Sleep or rest during day when baby is sleeping
- Coach mom to have visitors hold baby while mom sleeps
- Develop a routine to relax before bed

Clark, 2010; Lively, Perinatal Mental Health Project

Resources

- www.zerotothree.org

Clark and Fenichel(2001)Mothers, Babies and Depression

www.healthychild.ucla.edu

Zeanah, P. et al(2005)Addressing Social-Emotional Development and Infant Mental Health in Early Childhood Systems: Executive Summary- National Center for Infant and Early Childhood Health Policy

- www.nccp.org_791.html

Reducing Maternal Depression and its Impact on Young Children: Toward a Responsive Early Childhood Policy Framework-National Center for Children in Poverty

- www.postpartum.net

Postpartum Support International 1-800-944-4PPD

- www.perinatalweb.org

Screening for Prenatal and Postpartum Depression Position Statement

Wisconsin Association for Perinatal Care

- www.mededppd.org/aboutus.asp

Peer-reviewed professional and consumer education site supported by the National Institute for Mental Health(NIMH)

State of Wisconsin Perinatal Mood Disorders Task Force(DHFS)