PREVENTION

Postpartum Depression and the Mother- Infant Relationship: How Can Nurture Attachment

-by
Kathleen A. Kendall Tackett

In our culture, we have such pretty images of life with a new baby. The mothers are attractive and well-rested; the babies are either smiling or sleeping. And, of course, the house is spotless. Yet professionals who work with new mothers recognize that the postpartum period can be very stressful. It is a time when support can really make a difference. Perhaps at no other time are parents as eager to learn as when they are caring for a newborn. No wonder the postpartum period has been described as a "window of opportunity" for intervention in the lives of young families (Helfer et al., 1987).

As essential as support is to new mothers, the majority are left to go it alone. Not surprisingly, many mothers become depressed. Unfortunately, little empirical research simultaneously addresses issues of postpartum depression and child abuse and neglect, even though these appear to be co-appearing symptoms in many troubled families. We know that many women suffering from postpartum depression do not abuse their children, and that many people who do abuse their children are not at all depressed. This article will outline how postpartum depression can affect the mother and baby relationship, which is especially pertinent if we are concerned about mothers already at risk for abuse and neglect.

> ***Infanticide is the most sensational but not the most common effect of postpartum depression. The more pernicious effect of postpartum depression is that it can emotionally distance a mother from her infant, and therefore undermine the mother/infant relationship.***

Definition of Postpartum Depression

Simply put, postpartum depression is depression that occurs after a woman has a baby. It can occur at any time in the first postpartum year. Postpartum depression is a general term that refers to three conditions: postpartum blues, postpartum depression, and postpartum psychosis. "The blues" and "postpartum depression" are characterized by lability of mood, despair, hopelessness, helplessness, loss of appetite, loss of interest in the baby, anxiety, sleeplessness, or suicidal ideation. "The blues" are very common. In our culture, occurred in 50-85% of new mothers (O'Hara, 1987). They are considered less severe than depression, occur within the first two weeks postpartum, and are generally self-correcting. "Postpartum depression" is estimated to occur in approximately 10-20% of new mothers (O'Hara, 1987), and symptoms can occur any time in the first year. The line between the "blues" and depression is blurry. They have similar symptoms, and the blues may be either a less severe form of depression or a precursor to depression. Since the relationship between depression and the blues is unclear, and they lie on a continuum, it is essential that professionals working with new mothers take any symptoms of depression seriously, and not write them off as insignificant. Postpartum psychosis, the most serious condition, occurs at a rate of 1 to 2 per 1,000 women (O'Hara, 1987). Symptoms of postpartum psychosis include heightened or reduced activity; hallucinations; severe depression, mania or both; confusion; and delirium. It generally occurs within the first two weeks postpartum and may require hospitalization.

The Relationship Between Postpartum Depression and Child Abuse

We have all heard stories in the popular press about women killing their infants while suffering from postpartum psychosis. These stories provide the most salient examples of the relationship between child abuse and postpartum illness. Angela Thompson became delusional after she stopped nursing her son at age nine months. She drowned him in the bathtub after hearing the voice of God tell her that the baby was the devil (Toufexis, 1988). In another well-publicized case, Sheryl Massip drove her car over her six-week-old son after being compelled to do so by imaginary voices (Lachnit, 1990).

As horrifying as these examples are, however, the actual incidence of infanticide related to postpartum illness appears to be low. In the only empirical study of this phenomenon, 82 women who had been hospitalized for severe postpartum depression were followed upon their release. The infanticide rate among women who were identified as having the most severe cases of postpartum illness was 4% (Davidson & Robinson, 1985). Even though this incidence appears to be low, health professionals should realize that infanticide is a possibility, and be prepared to take appropriate action.

Infanticide is the most sensational but not the most common effect of postpartum depression. The more pernicious effect of postpartum depression is that it can emotionally distance a mother from her infant, and therefore undermine the mother/infant relationship. Postpartum depression can tip the scales if a mother is already at risk for abuse or neglect. Some mothers suffering from postpartum depression may become neglectful because they are unable to rally their resources in order to care for their children. Research reveals that maternal depression is similar to maltreatment in its effects on children's development. The findings on maternal depression include increased emotional, cognitive or social problems for the children (O'Hara, 1987); increased levels of behavioral disturbances at two months and three years (Whiffen & Gotlib, 1989; Wrate, Rooney, Thomas, & Cox, 1985); and lower IQ scores (Cogill et al., 1986). Field (1992) described how depressed mothers tend to show two different profiles of behavior: withdrawn or intrusive. The withdrawn mothers spent approximately 80% of their time disengaged from their infants and only responded to infant distress. The mothers with a more intrusive style expressed irritation or roughly handled their infants approximately 40% of the time. In either case, the infants of these depressed mothers showed depressive symptoms

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In my own research on postpartum depression, I conducted 23 in-depth interviews with women across the country. They were recruited from the National Office of Depression after Delivery, a self-help organization for women suffering from postpartum illness. All had suffered from either postpartum depression or psychosis. I have used their stories to illustrate many of the issues raised by research studies. Below is one woman's description of how postpartum depression affected her ability to care for her infant son:

"I didn't care about anything. I didn't want to eat, I couldn't even get out of bed. I couldn't tell my son was jaundiced. My mother kept saying, 'Your son is sick. You need to do something about your son,' as she tried for the tenth time that day to get me out of bed. That's when I realized how bad that depression was and that I needed help. Everyone could tell the baby was sick but me. I didn't even notice it. I don't know what I would have done if my mother hadn't been there" (Kendall-Tackett, with Kantor, 1993, p. 87)

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This woman's story was particularly poignant because she was generally a high-functioning mother, she had good support, and she was able to recognize a problem. This story may have turned out quite differently for a woman at greater risk for abuse or neglect.

Causes of Postpartum Depression

A broad range of factors contribute to postpartum depression including fatigue; negative birth experiences; infant characteristics; the mother's expectations, feelings of self-efficacy and self-esteem; and the mother's level of social support. Each woman who is affected by postpartum illness may be influenced by one or more of these factors. Below I highlight the factors that my research reveals have the most influence on the mother and baby relationship.

Fatigue and Sleep Deprivation. Sleep deprivation is a fact of life for new mothers. Perhaps because it is so common, its influence on a mother's emotional state is often overlooked. Fatigue can be due to a variety of factors, including infant characteristics; a difficult birth; or hypothyroidism, allergies, or anemia that develop in the postpartum period. Fatigue can also be a symptom of depression, which complicates our understanding of the relationship between fatigue and postpartum depression. Sleep deprivation also appears to have some relationship to postpartum psychosis, and several days of sleeplessness may precipitate a psychotic break (Lahey, 1992). When working with new mothers, it is important to take fatigue seriously (see Appendix for a screening instrument for postpartum fatigue). This might include helping mothers to develop strategies for getting more rest, screening for physical problems such as hypothyroidism, anemia, or allergies, and nutritional counseling aimed at modifying the mother's diet. One line of research has demonstrated a link between depression, serotonin levels, and the amount of complex carbohydrates a person consumes (Wurtman & Wurtman, 1989). Higher levels of carbohydrates in the diet were related to reduced levels of depression. Even validating a mother's feeling of fatigue can go a long way toward helping her cope.

Negative Birth Experiences. The effect of birth experiences on women's ability to parent is often overlooked as a variable in child abuse research. It is complicated enough to warrant a future article, but I will also briefly describe it here.

During labor, a woman is extremely vulnerable emotionally. Events that take place during those hours can have a long-range impact. One recent longitudinal study (Simkin, 1992) demonstrated that women could accurately remember details of their first births 20 years after the fact. If this experience is negative, it has been shown to affect how women relate to their babies. Below, two women describe how their frightening birth experiences affected their relationships with their babies for the first year and beyond. The first woman went into a coma for several days as a result of her delivery complications (eclampsia and renal failure), the second had an obstetric emergency (prolapsed cord).

> I woke up Wednesday and found out I had a baby girl. . . I knew I had a baby, but it didn't make any sense. I couldn't take care of her. The last thing on my mind was my baby. . . Sometimes I still feel like she's not really mine, that someone else could take her away, that I don't have the right to make decisions about how to take care of her. . . I'm afraid to give up nursing because it's the only tie that makes her mine (Kendall-Tackett, with Kantor, 1993; p 52).

> It's taken a long time to bond with my baby. I haven't had any of the "new mother" euphoria people talk about. I did not get to hold my daughter until 8:30 the next morning. I let the nurses take care of her. I just wasn't up to it. I didn't even change a diaper until I went home. It's still hard for me to think of myself as a mother, sometimes (Kendall-Tackett, with Kantor, 1993; p 52).

Providing women with a sense of control over their labor and delivery, and providing them with emotional support during labor have both been related to women's positive perceptions of their birth experiences. If a woman has a negative or troubling birth experience, she needs to be able to talk about it. Affonso (1977) found that women frequently need to resolve troubling aspects of

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policymakers, public agencies, and professional associations. The database, being offered by National Information Services Corporation in association with the National Clearinghouse on Child Abuse and Neglect Information, includes more than 17,00 citations and abstracts of professional literature produced from 1965 to the present Materials are culled from books, journals, government reports, conference papers, federally-funded grants, curricula, and unpublished papers.

Descriptors used in the databases are taken from the Child Abuse and Neglect Thesaurus containing over 1600 descriptor items. References are primarily to English-language materials originating in the United States The offering includes a free annual subscription with updated discs sent semi-annually.

Inquiries should be addressed to: National Clearinghouse on Child Abuse and Neglect Information, PO Box 1182, Washington, DC 20013-1182

Maternal and Child Health Application Deadlines

The U S. Bureau of Maternal and Child Health has announced 1994 application deadlines for new and competing renewal grant projects and cooperative agreements for special projects of regional and national significance under MCH federal set-aside program. Up to twenty five-year research grants will be awarded, with application deadlines March 1, 1994- August 1, 1994. Funding is also available for ten school health programs, due date to be announced; ten maternal, infant, child and adolescent health projects, due April 29, 1994; five data utilization projects, due June 15, 1994; ten Healthy Tomorrows Partnerships for Children, due May 2, 1994; and ten field-initiated projects, due between April 1, 1994 and August 15, 1994.

The complete announcement appears in the February 2, 1994 Federal Register on page 4925 For more information, please contact Chief, Grants Management Branch, Office of Program Support, Maternal and Child Health Bureau, Health Resources and Services Administration, Room 18-12, Parklawn Building, 5600 Fishers Lane, Rockville Maryland 20857; Phone (301)-443-1440

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their birth experiences so they can focus on the present and care for their babies

Childhood abuse of the mother. Surprisingly, there are no empirical studies linking childhood abuse to postpartum depression (although some anecdotal and clinical evidence suggests a link). However, a recent line of inquiry examines the effect of past child sexual abuse on birth, and indicates that past abuse can affect a woman's birth experience (e.g., Courtois & Riley, 1992; Grant, 1992). Some of these effects include flashbacks of the abuse during labor, and even an increase in medical interventions such as anesthsia, analgesia, and cesarean sections. In popular literature, some women describe their birth experiences as revictimizations. Future research may also reveal a direct relationship between past abuse and postpartum depression, and/or an indirect relationship between past abuse and postpartum depression through birth experiences.

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Infant Characteristics. Understanding the *infant's* role in postpartum depression is a relatively new, since most research has focused on the mother There have been two broad classes of infant characteristics that have been directly related to postpartum depression: infant temperament and infant illness "Difficult" infants are those who react negatively and cry frequently, are slow to accept new experiences, and do not engage in regular routines. In one study (Cutrona & Troutman, 1986), the authors found a direct causal link between infants with difficult temperaments and postpartum depression in their mothers The authors hypothesized that these infants contribute to the onset of depression since they diminish their mothers' feelings of self-efficacy and make them feel helpless These difficult infants are also at increased risk for being abused, perhaps because they do not soothe easily and cry a great deal (Schmitt, 1987). Below, two women describe how their children's temperaments made them feel out of control as mothers

> My first baby screamed from the day he was born He screamed all the time, even in the hospital. He reacted oddly to all kinds of different things The pediatrician said he was a "difficult" child. Even now, he has to have things always the same. When I went back for a checkup at two weeks, a nurse asked me how the baby was She said, "Aren't they wonderful?" I didn't know what to say I thought he was the pits (Kendall-Tackett, with Kantor, 1993, pp. 85-86).

> The baby had a difficult temperament Even now, she's very stubborn and strong willed I wanted this baby so bad When she came, I hated her. I thought of throwing her out the window. I just wanted her to die. I spanked her when she was 3 or 4 weeks old, and I'm still dealing with the guilt of it. I'd yell at her, right in her face, "I hate you I wish you would die." (Kendall-Tackett, with Kantor, 1993, pp 85-86)

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Another factor related to postpartum depression is the effect of infant illness, prematurity, or disability on the mothers' emotional state. Not surprisingly, illness of infants has also been causally linked to postpartum depression; the higher the risk for the infant, the greater the depression in the mother (Blumberg, 1980). Again, mothers may feel that they have no control and are powerless to help their babies. They may also be extremely anxious about their infants and may be experiencing anticipatory grieving.

Social support clearly affects not just post - partum depression but the mother/infant relationship. Lack of social support or connection with the community is an important correlation of child maltreat- ment. Similar findings emerge in the litera- ture on mother-infant bonding.

The goals in these cases are to help mothers resolve their grief and become attached to their infants. But their babies' illness may prompt emotional distance, making it difficult to resolve grief and attach to the infants. These babies may also react in unusual ways and be difficult to predict or read, thus lowering mothers' sense of self-efficacy. Mothers may perceive that their babies are rejecting them. In one study, mothers with the sickest babies became less responsive to them and responded negatively to their distress over time, whereas mothers of moderately ill babies improved over time (Jarvis et al., 1989). Again, these were not mothers otherwise at risk for abuse, and yet mother-infant bonding was strongly affected by their infants' illnesses.

Social Support. Providing women with adequate social support significantly lessens their chances of developing postpartum depression. A woman's husband or partner is a key source of support. Numerous research studies conducted with married women have demonstrated that both emotional and instrumental support from the woman's husband significantly decreases her risk of postpartum depression. Women who indicated that their husbands did not provide adequate support were significantly more likely to be depressed (e.g., Campbell, Cohn, Flanagan, Popper, & Meyers, 1992; O'Hara, 1986).

The support of peer networks is also very important. Two anthropologists (Stern & Kruckman, 1983) noted that in many cultures, postpartum depression, and even transient postpartum blues, are virtually non-existent. This is in stark contrast to Western cultures, where the blues are so common that we assume that they are inevitable. Stern and Kruckman have analyzed the protective elements of these non-Western cultures. In particular, they note that in cultures with a low incidence of postpartum depression, many elaborate rituals are enacted that take place after a woman has given birth. These rituals serve several functions, including (1) giving the mother time to recuperate, (2) offering her respite from her daily activities, and (3) recognizing her status as a new mother. In at least one of these cultures, well-wishers give presents to the mother and a special "stepping out" ceremony takes place within a few weeks of her giving birth. Stern and Kruckman describe these rituals as "mothering the mother," which is also an important aspect of the "doula" movement in the United States (Klaus et al., 1993; Raphael, 1976). "Doula" is a term that is used both for a woman who attends a laboring woman and for a woman who provides postpartum support. Clearly, this type of postpartum care is not the norm for the majority of mothers in the U.S. This absence of care for the mother is a cause of great concern, especially since maternity hospital stays are now being reduced to 24 hours with no follow-up care.

Social support clearly affects not just postpartum depression but the mother-infant relationship. Lack of social support or connection with the community is an important correlate of child maltreatment (Polansky, Gaudin, Ammons, & Davis, 1985). Similar findings emerge in the literature on mother-infant bonding. For example, instrumental social support has been related to mothers being able to be more sensitive to their infants in the first year of life (Crockenberg & McCluskey, 1986). This trend continued until the children were older. In a study of 38 mother-child dyads (with children ages 27 to 55 months), the more support a mother received in her role as a parent, the better were her interactions with her child. This result applied to mothers who were single parents as well as to those who were in two-parent families (Weinraub & Wolf, 1987).

Conversely, perceived lack of support from fathers was related to insecure attachments between 34 Japanese mothers and their 12-month-old infants (Durrett, Otaki, & Richards, 1984). The authors interpreted their findings by stating that mothers who did not have support may have had higher levels of stress, and were therefore psychologically unavailable to their infants. Other research found that lack of social support was also characteristic of mothers who neglected their children, even when controlling for the effects of socioeconomic status (Polansky, Gaudin, Ammons, & Davis, 1985). Social support also facilitated attachment between mothers and their handicapped infants (Capuzzi, 1989), as well as mothers and their premature infants (Crnic et al., 1986). In general, mothers with high support are more satisfied with their babies, their maternal roles, and their lives overall (Crnic & Greenberg, 1987).

Knowing that social support is so essential to new mothers, it is important to keep in mind that what helping professionals think of as support is not necessarily support for the new mothers. "Support groups" or "nurse home visits" are often suggested to to prevent postpartum depression, and "parent education" is also frequently suggested for preventing child abuse. These types of intervention do work for some families, but not for everyone. One recent study involving visiting nurses (Affleck, et

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al., 1989) demonstrated that for the intervention to be effective, the recipient must *perceive* it as support. If she does not perceive the support as helpful, it can actually make matters worse. The bottom line is that these programs are most successful when the mother sees a need for them and/or when the mother feels nurtured and cared for.

Suggestions for the Field

1. **Be alert for possible postpartum depression**. Postpartum depression is a problem in and of itself, and can also indicate other problems within the family. Using a screening instrument such as the *Edinburgh Postnatal Depression Scale* is often helpful (see Appendix p.38).

2. **Don't assume you know the cause of the woman's distress**. Postpartum depression is caused by such a wide variety of factors that it is unwise to assume you know which ones are involved for a particular woman. Many mothers I've spoken to have told me how frustrating it was when someone kept trying to tell them why they were depressed. In the same way, don't assume that the same intervention will work for everyone. If at all possible, offer women a variety of options and let her choose those with which she is most comfortable. Treatment could include support groups, psychotherapy, social support (including practical assistance with the baby), physical screening for medical problems that might increase fatigue, and antidepressant medications.

3. **Find out about resources in your community**. Many professionals do not get involved with the concerns of new mothers because they feel that cannot provide the needed support. The good news is that *you don't have to*. Find out about groups working with new mothers, and don't limit your search to organizations concerned with child abuse. I was recently impressed as I listened to La Leche League leaders describe some of their "helping calls." La Leche League leaders are volunteer mothers who provide breastfeeding support and assistance. It was apparent that they were helping to prevent child abuse in many cases as mothers called them when they were at their wits' end. Yet this group is never included in child abuse prevention programs. Many organizations have toll-free numbers for women to call when they have questions or concerns. Find out about these organizations and tell the mothers you work with about them (see Appendix p.38 for a list).

Knowing that social support is so essential to new mothers, it is important to keep in mind that what helping professionals think of as support is not necessarily support for new mothers.

4. **Consider some activism on behalf of new mothers**. Contact HMO's or hospitals in your community and express your concerns about the possible outcomes on families of 24-hour maternity discharges with no follow-up care. Suggest that they offer follow-up care, mentioning that it is likely to save them money in the long run (see Appendix p 38 for organizations that can help).

Conclusion

Providing support for new mothers is well worth our efforts. By nurturing women during this vulnerable time, we can prevent both postpartum depression and at least some child abuse and neglect.

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RESOURCES FOR INTERVENTION WITH NEW MOTHERS

Single copies of instruments for assessing postpartum fatigue and postpartum depression (*Edinburgh Postnatal Depression Scale)* are available at no cost from:
The Perinatal Education Group, 129A Concord St., Suite 38, Framingham, MA 01701
These can be copied for individual use

ORGANIZATIONS THAT WORK WITH NEW MOTHERS

C/SEC (Cesarean/Support, Education, Concern)
22 Forest Rd.
Framingham, MA 01701
(508) 877-8266

Depression After Delivery, National
P.O. Box 1282
Morrisville, PA 19067
(215) 295-3994

Federation for Children with Special Needs
95 Berkeley St., Suite 104
Boston, MA 02116
(617) 482-2915

International Cesarean Awareness Network (I CAN)
P.O. Box 152
Syracuse, NY 13210
(315) 424-1942

LaLeche League International
9616 Minneapolis Ave
Franklin Park, IL 60131
(708) 455-7730
(800) LaLeche

National Association of Mothers' Centers
336 Fulton Ave.
Hempstead, NY 11550
(800) 645-3828

National Association of Postpartum Care Services
c/o MotherCare, Inc.
17 Highland
Lexington, MA 02173
(617) 863-1333

National Down Syndrome Congress
1800 Dempster St.
Park Ridge, IL 60068
(708) 823-7550
(800) 232-6372

National Information Center for Children and Youth with Handicaps
P O Box 1492
Washington, D.C. 20013
(800) 999-5599

National Organization of Mothers of Twins Clubs, Inc.
P.O. Box 23188
Albuquerque, NM 87192-1188
(505) 275-0955

Parents Anonymous, National
520 S. Lafayette Park Pl.,
Suite 316
Los Angeles, CA 90057
(213) 388-6685
(800) 421-0353