Perinatal Mood Disorders

**Postpartum Blues**
Prevalence: 50-80% of new mothers
Onset: Within hours or days of delivery
Duration: 10-14 days
Symptoms: emotional lability, anxiety, fatigue, insomnia, anger, sadness, irritability
Symptoms come and go
Considered normative

**Postpartum Psychosis**
Prevalence: 1/1000 births (.1%)
Onset: Usually occurs in 1st week following birth, sudden onset
Symptoms: Agitation, racing thoughts, rapid speech, severe insomnia, hallucinations, paranoia, irrational speech or behavior, poor reality testing, threats of suicide and/or infanticide
A medical emergency requiring immediate care

**Postpartum Depression**
Prevalence: 8-15% of new mothers
Up to 50% for women living in poverty
Can begin anytime in first year
Lasts at least two weeks
Anxiety may be a prominent symptom
30-70% may experience the disturbance for one year or longer

**DSM Criteria for Major Depressive Episode in the Postpartum Period**
5 or more of the following symptoms:
- Depressed mood, often accompanied by severe anxiety
- Markedly diminished interest or pleasure in activities
- Appetite disturbance
- Sleep disturbance
- Physical agitation or psychomotor slowing
- Fatigue, decreased energy
- Feelings of worthlessness or inappropriate guilt
- Decreased concentration or inability to make decisions
- Recurrent thoughts of death or suicidal ideation

*Symptoms (including one of the first two) present most of the day, nearly every day for at least 2 weeks*

**Risk Factors for PPD:**
- Symptoms of depression or anxiety during pregnancy
- Past depression/mood disorders
- Family history of depression
- Complications in pregnancy, birth, or breast feeding
- Relational and/or financial stress
- Inadequate social support in caring for the baby
- Physical conditions such as Thyroid disorder or PMDD (PMS)
- Major life event (eg. loss, housing, employment)
- Physical health problems in the mother or infant

**Moms report...**
Overwhelmed
Anxious, worried
Feeling constantly tired
Awake with thoughts running through head
Crying often
Not enjoying being a mother
Feeling disconnected from their baby
Feeling like a bad or inadequate mother
Anger or extreme irritability toward others
Anxiety Disorders Commonly Occurring During the Perinatal Period

Postpartum Anxiety Disorders
Anxiety, particularly panic and fears/obsessions about the care and safety of the baby, may be initially reported as more distressing by women than depressed mood. This can be confusing for women or providers if only looking for depressive symptoms postpartum.

Panic Disorder
Features of a panic attack:
• A sudden period of intense fear or discomfort
• Abrupt development of physical symptoms: heart racing/palpitations, sweating, shaking, shortness of breath, feeling of choking, chest pain, nausea, dizziness
• Often accompanied by fear of dying

Obsessive/Compulsive Disorder
Recurrent, persistent thoughts or images, often of harming the baby
Experienced as intrusive and distressing
A sense of horror about the obsessions
Fear of being left alone with the infant
Hypervigilance in protecting the infant
Moms with postpartum OCD know that their thoughts are bizarre and are very unlikely to ever act on them.
Not necessarily associated with increased risk of harm to baby, however an evaluation should still be conducted by a mental health professional.
Still important to discuss thoughts of harm, address contributing stressors, and create a safety plan

Posttraumatic Stress Disorder
Women who have experienced a previous trauma, such as rape, domestic violence or physical/sexual abuse, are also at a higher risk for experiencing postpartum PTSD.
Symptoms of postpartum PTSD might include:
• Intrusive re-experiencing of a past traumatic event (which in this case may have been the childbirth itself)
• Flashbacks or nightmares
• Avoidance of stimuli associated with the event, including thoughts, feelings, people, places and details of the event
• Persistent increased arousal (irritability, difficulty sleeping, hypervigilance, exaggerated startle response)
• Anxiety and panic attacks
• Feeling a sense of unreality and detachment

Social Anxiety Disorder (Social Phobia)
The person has an excessive and unreasonable fear of social situations
Anxiety, intense nervousness and self-consciousness arise from a fear of being closely watched, judged, and criticized by others.
The anxiety can build into a panic attack.
As a result of the fear, the person endures certain social situations in extreme distress or may avoid them altogether.
People with social anxiety disorder often suffer "anticipatory" anxiety -- the fear of a situation before it even happens -- for days or weeks before the event.
The person is aware that the fear is unreasonable, yet is unable to overcome it.

Symptoms of Anxiety
Excessive worry
Difficulty controlling the worry
Feeling like something bad is going to happen
Restlessness or feeling keyed up
Fatigue
Difficulty concentrating or "mind going blank"
Irritability
Muscle tension
Sleep disturbance

Risk Factors for Anxiety Disorders
• Personal history of anxiety
• Family history of anxiety
• Previous personal history of anxiety
• Thyroid imbalance
Personality Disorders and Other Disorders Commonly Impacting the Perinatal Period

**Borderline Personality Disorder**
Often characteristic of people with a history of trauma.
Mothers relationships with their young child is characterized by:
- Emotional under-involvement (lack of emotional availability/empathy)
- Behavioral over-involvement (intrusiveness and control)
- Lack of Reflective Functioning or Mentalization-capacity to see their child as a separate individual
- Less sensitive, attentive and structuring
- Feel less competent, less satisfied and more distressed in the mothering role
- Difficulty sharing other's empathy with their child

**Symptoms of Borderline Personality Disorder:**
A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
- Frantic efforts to avoid real or imagined abandonment. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- Identity disturbance: markedly and persistently unstable self-image or sense of self.
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- Transient, stress-related paranoid ideation or severe dissociative symptoms

**Bipolar Disorder**
Family history is a major risk factor and can be brought on by stress or lack of sleep
Features of a Manic Episode: Unusually and persistently high mood or unusual irritability for at least one week. Must be severe enough to disrupt ability to function at home, work or school and be associated with many of these additional symptoms:
- Increased physical energy and mental activity
- Feelings of extreme wellbeing
- Inflated or elevated self-esteem
- Fast or pressured speech, racing or crowded thoughts
- Extreme irritability
- Easily distracted
- Needing less sleep
- Poor judgment
- Spending sprees
- Increased sexual drive
- In most severe cases, the individual may believe in things that are not true (delusions) and think they see, hear and smell things that are not real (hallucinations).

**Obsessive Compulsive Personality Disorder** (Four or more of the below characteristics)
- Perfectionistic tendencies
- Preoccupied with details, rules, lists, or schedules
- Perfectionism that interferes with task completion
- Excessive focus on work to exclusion of leisure or friendships
- Rigid morality or values
- Unable to discard worthless objects of no sentimental value
- Reluctant to delegate tasks unless done her way
- Hoarding of money for future catastrophes
- Rigid and stubborn
Case #1

Brianna is a 20 year old woman who gave birth to a baby girl ten weeks ago. She has a 2 ½ year old son who she describes as “hyper” and “a trouble maker”. She says that this baby is “quiet so far” and “sleeps pretty good”. Brianna returned to work at 6 weeks postpartum and states that she feels tired all the time and hates dropping her baby off at childcare because she doesn’t feel comfortable with the place she is leaving her. When you enter the home, the blinds are mostly closed and the TV is on. As you ask Brianna about her history with depression or anxiety, she tells you that she has been depressed on and off “pretty much her whole life” and that she did feel depressed during pregnancy but did not seek treatment because she did not want to take medication.
Case #2

Julia is a 25 year old woman who delivered a baby boy, her first child, 3 months ago. She seems tense and jittery, and bounces her knee constantly as she talks to you with her baby on her lap. She asks you lots of questions about how to help her baby sleep better, how to tell if he’s eating enough, how often she should give him baths, if he should be spitting up this much, etc. She mentions that she can’t keep asking her pediatrician because he seems frustrated with all of her questions and phone calls. She also shares that she worries a lot about her baby’s safety, because she never wants him to be hurt the way she was when she was little. The home is neat and well kept, and you notice the baby has a bit of a rash around his mouth where Julia frequently wipes his spit-up. When asked about past history of depression or anxiety, Julia states that she has never had any problems like that before, but acknowledges that she hasn’t quite felt like herself since her baby was born.
MOTHER-BABY GROUP
TIP SHEET
Meets for 40 minutes, following the Mothers’ and Infant groups

Goals for Mom and Baby Group
• Consider and respond to mothers’ needs so they can respond to those of their baby
• Provide safe environment for mother to explore alternative ways of interacting with the baby
• Enhance parents’ understanding of infants’ developmental needs
• Increase interactions which support the infants’ development
• Provide experiences which enhance mother’s sense of competence in the mothering role
• Provide more mutually enjoyable times of interaction for mother and baby
• Increase baby’s responsiveness to mother

Dyadic Support Person Techniques:
❖ Being aware of and checking in about mother’s emotional state
❖ Capacity to hold mother and baby in mind at the same time
❖ Empathic coaching to support mother-baby interactions
❖ Supporting mom in reading her baby’s cues
❖ Speaking for the baby
❖ Amplify positive affect
❖ Reflecting with mom about what works for her baby
❖ Providing positive feedback and reinforcement to the mother
❖ Adjusting the infant’s physical positioning to support eye contact and mother-baby interaction
❖ "Wondering along" with mom about what is “going on” for her baby
❖ Modeling narrating baby’s play
❖ Supporting a mother-baby dyad in a mutually enjoyable joint activity
❖ Extending mom's constructive initiative with her baby
❖ Engaging mothers in trying new or alternative approaches in mother-baby interactions
❖ Supporting a mother-baby dyad in reciprocal interaction (e.g. closed loops, contingent responsivity, turn-taking)
❖ Supporting a mother-baby dyad in organizing, pacing and regulating their interactions
❖ Helping to modulate emotions that disrupt interaction (both mom's and baby's)
❖ Offering non-judgmental developmental guidance
The attached 10-item Edinburgh Postnatal Depression scale (EPDS; Cox, Holden, & Sagovsky, 1987) is provided for your use to screen new mothers for postpartum depression. The EPDS was developed specifically to identify significant depressive symptoms among pregnant women and new mothers. The EPDS is one of the mostly widely used screening tools for the detection of depression during the postpartum and antenatal periods. It has been validated in a number of countries, cultures, settings, and large community samples (i.e., Boyce, Stubbs & Todd, 1993; Cox, Chapman Murray & Jones, 1996; Holt, 1995; Jadresic, Araya, & Jara, 1995; Wickenberg & Hwang, 1996; Zelkowitz & Milet, 1995). In the research literature, sensitivity rates on the EPDS range from 93% to 100% and specificity rates range from 78% to 90%. Items on the EPDS emphasize the frequency with which a particular item has occurred or the severity of a symptom during the past week (ranging from 0 to 3; total scores range from 0 to 30). A **cutoff score of 9 or higher** identifies women with significant depressive symptoms.
Circle the number for 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.

0. As much as I always could
1. Not quite so much now
2. Definitely not so much now
3. Not at all

I have looked forward with enjoyment to things.

0. As much as I ever did
1. Rather less than I used to
2. Definitely less than I used to
3. Hardly at all

I have blamed myself unnecessarily when things went wrong.

0. No not at all
1. Hardly ever
2. Yes, sometimes
3. Yes, very often

I have felt anxious or worried for no good reason.

0. Yes, quite a lot
1. Yes, sometimes
2. No, not much
3. No, not at all

I felt scared or panicky for no very good reason.

0. Yes, quite a lot
1. Yes, sometimes
2. No, not much
3. No, not at all

Things have been getting on top of me.

0. Yes, most of the time I have not been able to cope at all
1. Yes, sometimes I have not been coping as well as usual
2. No, most of the time I have coped quite well
3. No, I have been coping as well as ever

I have felt so unhappy that I have had difficulty sleeping.

0. Yes, most of the time
1. Yes, sometimes
2. Not very often
3. No, not at all

I have felt sad and miserable.

0. Yes, most of the time
1. Yes, quite often
2. Not very often
3. No, not at all

I have been so unhappy that I have been crying.

0. Yes, quite often
1. Only occasionally
2. No, never

The thought of harming myself has occurred to me.

0. Yes, quite often
1. Sometimes
2. Hardly
3. Never

Column Total = ____________
Column Total = ____________
Total = ____________


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Como usted hace poco tuvo un bebé, nos gustaría saber como se ha estado sintiendo. Por favor haga un círculo alrededor de la respuesta que más se acerca a como se ha sentido en los últimos 7 días.

En los últimos 7 días:

**He podido reír y ver el lado bueno de las cosas.**
- [ ] Tanto como siempre
- [ ] No tanto ahora
- [ ] Mucho menos
- [ ] No, no he podido

**Las cosas me oprimen o agobian.**
- [ ] Sí, casi siempre
- [ ] Sí, a veces
- [ ] No, casi nunca
- [ ] No, nada

**He mirado al futuro con placer.**
- [ ] Tanto como siempre
- [ ] Algo menos de lo que solía hacer
- [ ] Definitivamente menos
- [ ] No, nada

**Me he sentido tan infeliz, que he tenido dificultad para dormir.**
- [ ] Sí, casi siempre
- [ ] Sí, a menudo
- [ ] No muy a menudo
- [ ] No, nada

**Me he sentido triste y desgraciada.**
- [ ] Sí, casi siempre
- [ ] Sí, bastante a menudo
- [ ] No muy a menudo
- [ ] No, nada

**He estado ansiosa y preocupada sin motivo.**
- [ ] Sí, a menudo
- [ ] Sí, a veces
- [ ] Casi nada
- [ ] No, nada

**He estado tan infeliz que he estado llorando.**
- [ ] Sí, bastante a menudo
- [ ] Sí, a menudo
- [ ] Casi nunca
- [ ] No, nunca

**He pensado en hacerme daño a mí misma.**
- [ ] Sí, bastante a menudo
- [ ] Sí, a menudo
- [ ] Casi nunca
- [ ] No, nunca

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**EPDS (Practice Case #1)**

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

<table>
<thead>
<tr>
<th>Statement</th>
<th>Response Options</th>
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</table>
| I have been able to laugh and see the funny side of things.               | ③ As much as I always could  
① Not quite so much now  
② Definitely not so much now  
④ Not at all |
| Things have been getting on top of me.                                    | ③ Yes, most of the time I have not been able to cope at all  
② Yes, sometimes I have not been coping as well as usual  
① No, most of the time I have coped quite well  
⑦ No, I have been coping as well as ever |
| I have looked forward with enjoyment to things.                            | ⑦ No not at all  
⑤ Hardly ever  
③ Yes, sometimes  
① Yes, very often |
| I have felt so unhappy that I have had difficulty sleeping.                | ⑦ Yes, most of the time  
⑤ Yes, sometimes  
① Not very often  
⑦ No, not at all |
| I have blamed myself unnecessarily when things went wrong.                 | ③ Yes, quite a lot  
② Yes, sometimes  
① No, not much  
⑦ No, not at all |
| I have felt sad and miserable.                                             | ③ Yes, most of the time  
② Yes, quite often  
① Not very often  
⑦ No, not at all |
| I have been anxious or worried for no good reason.                        | ③ Yes, quite a lot  
② Yes, sometimes  
① No, not much  
⑦ No, not at all |
| I have been so unhappy that I have been crying.                            | ③ Yes, most of the time  
② Yes, quite often  
① Only occasionally  
⑦ No, never |
| The thought of harming myself has occurred to me.                         | ③ Yes, quite often  
② Sometimes  
① Hardly  
⑦ Never |

| Column Total = _________ | Column Total = _________ | Total = ________ |


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### EPDS (Practice Case #2)

Circle the number for 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.**
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**Things have been getting on top of me.**
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**I have looked forward with enjoyment to things.**
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**I have felt so unhappy that I have had difficulty sleeping.**
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**I have blamed myself unnecessarily when things went wrong.**
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**I have been anxious or worried for no good reason.**
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**I have been so unhappy that I have been crying**
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**I felt scared or panicky for no very good reason.**
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**The thought of harming myself has occurred to me.**
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# Parent-Child Early Relational Assessment

## RELATIONAL PROFILE

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<th>Area of Concern</th>
<th>Area of Some Concern</th>
<th>Area of Strength</th>
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### PARENTAL DOMAINS

**Parent Tone of Voice**

1. Annoyed, Angry, Hostile
2. Flat, Unemotional, Constricted
3. Warm, Kind

**Parent Affect**

4. Expressed Positive Affect
5. Expressed Negative Affect

**Parent’s Characteristic Mood**

6. Irritable, Frustrated, Angry Mood
7. Depressed Mood
8. Anxious Mood
9. Enthusiastic, Animated, Cheerful, “Joie de Vivre” Mood
10. Hypomanic Mood/Behavior

**Parent’s Expressed Attitudes Toward Child**

11. Displeasure, Disapproval, Criticism
12. Enjoyment, Pleasure

**Parental Affective and Behavioral Involvement**

13. Quality and Amount of Physical Contact: Positive
14. Quality and Amount of Physical Contact: Negative
15. Amount and Quality of Visual Contact with Child
16. Amount of Verbalization
17. Quality of Verbalizations
18. Social Initiative
19. Contingent Responsivity to Child’s Positive or Age-Appropriate Behavior
20. Contingent Responsivity to Child’s Perceived Negative and/or Unresponsive Behavior
21. Structures and Mediates the Environment
22. Parent Reads Child Cues and Responds Sensitively and Appropriately
23. Connectedness
24. Mirroring

**Parent Style**

25. Flexibility/Rigidity
26. Creativity/Resourcefulness
27. Intrusiveness
28. Consistency/Predictability
29. Evidence of Behavioral Disturbances

### Behavioral Observations:


### INFANT/CHILD DOMAINS

**Child Mood/Affect**
- 30) Expressed Positive Affect
- 31) Expressed Negative Affect
- 32) Happy, Pleasant, Content, Cheerful Mood
- 33) Apathetic/Withdrawn/Depressed Mood
- 34) Anxious/Tense/Fearful Mood
- 35) Irritable/Frustrated/Angry Mood
- 36) Sober/Serious Mood
- 37) Emotional Lability

**Child Behavior/Adaptive Abilities**
- 38) Alertness/Interest
- 39) Social Behavior of Infant/Child- Initiates
- 40) Social Behavior of Infant/Child- Responds
- 41) Avoiding/Averting/Resistance
- 42) Compliance/Noncompliance
- 43) Assertion/Agressivity
- 44) Motoric Competence and Quality
- 45) Quality of Exploratory Play
- 46) Attentional Abilities
- 47) Robustness
- 48) Persistence
- 49) Impulsivity

**Behavioral Observations:**

**Child Activity Level**
- 53) Passivity/Lethargy
- 54) Hyperactivity

**Child Communication**
- 55) Visual Contact
- 56) Communicative Competence
- 57) Readability

### DYADIC DOMAINS

**Affective Quality of Interaction**
- 58) Frustrated, Angry, Hostile
- 59) Flat, Empty, Constricted
- 60) Tension, Anxiety
- 61) Mutual Enthusiasm, Joyfulness, Enjoyment, Dyadic “Joie de Vivre”

**Mutuality in Interaction**
- 62) Joint Attention, Activity
- 63) Reciprocity
- 64) Organization/Regulation of Interactions
- 65) Goodness of Fit

**Behavioral Observations:**
Parent-Infant Relationship Support Plan

<table>
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<tr>
<th>Relationship Issues to be addressed</th>
<th>Goals</th>
<th>Strategies/ Approaches</th>
<th>Progress</th>
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<tr>
<td>In mother-baby sessions</td>
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Name of Mother: _____________________________________  Name of Baby:___________________________________  Child’s Age_________________

Mother’s Signature ___________________________  Mother-Baby Support Person’s Signature ___________  Date ___________
Resources for Additional information on Perinatal Mood Disorders

www.referweb.net/mchh
State of Wisconsin MCH Hotline 1-800-722-2295

• www.postpartum.net
Postpartum Support International 1-800-944-4PPD
Warmline and excellent self-help and provider information

• www.perinatalweb.org
Wisconsin Perinatal Foundation
Screening for Prenatal and Postpartum Depression Position Statement
PPD materials for Latina and Hmong women
PPD treatment algorithm and Antidepressant Medication Comparison Chart

• www.mededppd.org/aboutus.asp
Peer-reviewed professional and consumer education site supported by the National Institute for Mental Health (NIMH)

www.womensmentalhealth.org
Massachusetts General Hospital Center for Women’s Health, a perinatal and reproductive psychiatry information center

www.nj.gov/health/fhs/postpartumdepression/index.shtml
State of New Jersey Dept. of Health and Senior Services

• www.zerotothree.org
Excellent web-site for parent, infant and early childhood mental health and development information

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

State of Wisconsin Perinatal Mood Disorders Task Force (DHFS)
“More than Just the Blues” Brochure-includes EPDS screener and information for women and family members

http://www.pbs.org/thisemotionallife/topic/postpartum
This Emotional Life, PBS Informational Web-site and Blogs

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

toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT
LACTMED Search - Search medications to find data regarding safety for breastfeeding

www.otispregnancy.org
OTIS (Organization of Teratology Information Specialists) - 866-626-6847 to speak with a counselor who can offer information on exposures during pregnancy or lactation. Website has many fact sheets on common medications
VIDEO REPLAY INTERVIEW

Name: ___________________________  Date: __________________________

Video Replay:
The semi-structured interview format is used in conjunction with the videotape to “wonder along” with the mother about her perceptions, attitudes and goals during the interaction with her baby. Objective assessments often fail to answer questions about what a parent is experiencing with their baby; the video replay interview allows the parent to share what she was seeing, doing and feeling in relation to her baby and her perceptions of the baby and herself as a parent.

1. Parents’ Subjective Assessment of Interaction
   Before the tape is replayed for the parent, ask:
   a. How was this interaction alike or different from how things usually go at home for you and ________?
   b. What was the most enjoyable part of this session for you?
   c. What part was the most difficult or did you like the least?
   d. Do you have any questions or comments about the taping?

2. Videotape Replay Interview
   During the replay, obtain the parents’ subjective perception of the baby’s behavior and themselves in the parenting role. Start out by saying: “While we review the tape, I’d like to ask you some questions about your baby and yourself”. Then, replay the tape and stop at points where the following aspects of the relationship can be focused upon:
   a. Meaning of the Baby to the Parent
      Stop the tape at a point when the baby’s face can be seen clearly on the screen. As you use the following questions to explore who this baby is to the parent, be listening for the ways in which any projections may influence the way the parent sees or feels about the baby.
      1. Who does ________ look like?
2. I wonder who s/he reminds you of….
   
a. In looks/physical features:
   
   b. In temperament or personality:
   
3. How would you describe your baby?

4. How did you select his/her name?
   
a. If s/he was named for someone (e.g., a relative, character from TV, etc),
      find out what that person was like:

   b. Parents’ Capacity to Read Baby’s Cue
      Stop the tape at a point when the parent is not responding to the baby’s cues or the parent seems to
      have difficulty responding to the baby empathically. Determine if it is difficult for the parent to
      read the baby’s cues, if parent misinterprets cues or if the parent attributes negative intentionality
      to the baby. Start out by saying, “Let’s take a look at another part of the tape”. Then, use the
      following questions to assess how the parent felt during the interaction and his/her capacity to see
      the baby as a separate individual:

      1. How was this time with your baby for you?
      
      2. I wonder what you were feeling then?
3. What do you imagine was going on for your baby?

4. What do you imagine s/he was wanting/needing/feeling?

It is often useful to explore how the parent’s own relational history (experience of being parented) affects their parenting behavior during this video segment. For example, if a parent experienced a lack of nurturance and/or harsh discipline, it may feel difficult to know what to do in the parenting role in the absence of a healthy model. If there was severe deprivation and/or abuse, and the parent’s emotional needs were consistently unmet, it may be difficult for them to be closely attuned to their baby’s emotional needs.

5. How do you imagine it was for you when you were a baby/baby and needed something from your mother or father?

6. What do you remember about being parented when you were young?

7. What three adjectives would you use to describe your relationship with your mother?

8. What three adjective would you use to describe your relationship with your father?

9. Could you describe an example when your mother was ____________(ask for each of the three adjectives)
10. Could you describe an example when your father was ______________ (ask for each of the three adjectives)

11. Who was available/responsive to you?

12. Who provided nurturance and affection?

13. Who kept you safe or not (physically, emotionally)?

14. How was discipline handled?

15. How would you compare yourself to your own parents?

c. Reinforcement Value of the Baby/Dyad’s Capacity for Enjoyment
   Stop the tape at a point when the parent and baby are experiencing a mutually satisfying interaction and/or the baby is responding positively. Start out by saying, “Let’s look at one more part of the tape”. The following questions will allow you to assess how the parent was feeling during the interaction, as well as what the parent thinks s/he did to elicit the positive response:

   1. How was this time with your baby for you?

   2. I wonder what you were feeling then?
3. What do you imagine was going on for your baby?

4. What do you imagine s/he was wanting/needings/feeling?

5. What do you imagine you did to help bring about this positive response for your baby?

Parent-Infant Relationship Development Planning
After reviewing the tape, use the information generated above, as well as responses to the following questions if necessary, to generate goals with the parent to enhance the parent-infant relationship.

a. How would you describe yourself as a parent?

b. In general, what have you found most difficult or frustrating about being a parent?

c. What have you found most enjoyable about being a parent?

d. When do you feel best, or when do you feel you have done well as a parent?

e. What would you like to focus on (or have some help with) during our time together?

Fill out the Parent-Infant Relationship Development Plan (i.e., initial goals)
Screening and Supportive Interventions for Maternal Depression and Mother-Infant Relationships in the Context of Home Visiting

March 6, 2017
Roseanne Clark, PhD, IMH-E® (IV)
Jen Perfetti, LPC, IMH-E® (IV)
Postpartum Depression Program
UW School of Medicine and Public Health

Reflection…
When I’m feeling low… What do I need most?

A mom’s own words…

Perinatal Mental Health Disorders: Signs, Symptoms & Risk Factors

Postpartum Blues

- Prevalence: 50-80% of new mothers
- Onset: Within hours or days of delivery
- Duration: 10-14 days
- Symptoms: emotional lability, anxiety, fatigue, insomnia, anger, sadness, irritability
- Symptoms come and go
- Considered normative
Postpartum Psychosis
- Prevalence: 1/1000 births (.1%)
- Onset: Usually occurs in 1st week following birth, sudden onset
- Symptoms: Agitation, racing thoughts, rapid speech, severe insomnia, hallucinations, paranoia, irrational speech or behavior, threats of suicide and infanticide
- A medical emergency requiring immediate care

Postpartum Depression (PPD)
- Prevalence: 10-15% of new mothers
  - Up to 50% for women living in poverty
- Can begin anytime in first year
- Lasts at least two weeks
- Anxiety may be central
- 30-70% may experience the disturbance for one year or longer without treatment

DSM criteria for Postpartum Depression
- 5 or more of the following symptoms:
  - Depressed mood, often accompanied by severe anxiety
  - Markedly diminished interest or pleasure in activities
  - Appetite disturbance
  - Sleep disturbance
  - Physical agitation or psychomotor slowing
  - Fatigue, decreased energy
  - Feelings of worthlessness or inappropriate guilt
  - Decreased concentration or inability to make decisions
  - Recurrent thoughts of death or suicidal ideation

Major Depressive Episode with Postpartum Onset
Symptoms present most of the day, nearly every day for at least 2 weeks

Case Example: Major Depressive Disorder
Marie: I have a three month old baby and I have been waiting to feel like myself again, but I don’t know whether I’ll ever be me again. When I really look back on it, there were some changes during pregnancy. As I became bigger and more uncomfortable, everything in life just felt harder. I was in physical pain a lot of the time, I couldn’t sleep well, I felt life as I knew it slowly disappearing. I thought it would get better when I stopped being pregnant and had my baby. My baby arrived and there were moments of joy, but they felt fleeting. Most of the time I felt in a fog, a dark hole where I didn’t exactly feel sad, I just felt nothing. I cried sometimes, other times I just felt empty. I saw others around me experiencing life as they always had and didn’t know if I would ever feel that again. My baby was fussy and it seemed that everyone else could calm her better than I could. Getting something done in the day, even a simple shopping errand, felt impossible. It was so hard to find the right time to leave the house when the baby wasn’t sleeping or needing to be changed, to get all of our things together, and once I got there I couldn’t even make small decisions about what ingredients to buy for a meal. I was having trouble sleeping, laying there in bed even when my baby was sleeping, and I’d forget to eat because nothing seemed appetizing. I had the life I had been wanting, I just couldn’t figure out why it all felt so difficult and empty.

Moms Report feeling...
- Overwhelmed
- Anxious, worried
- Feeling constantly tired
- Awake with thoughts running through head
- Crying often
- Not enjoying being a mother
- Feeling disconnected from their baby
- Feeling like a bad or inadequate mother
- Anger or extreme irritability toward others

Risk Factors for PPD
- Symptoms of depression or anxiety during pregnancy
- Past depression/mood disorders
- Family history of depression
- Perceived negative birth experiences
- Quality of social support/marital satisfaction
- Living in poverty
- Physical health problems in the mother or infant
- Significant loss or life stress in the last year
**Paternal Depression**

- Depression in about 7-10% of fathers
- Rates are higher in the 3-6 month postpartum period and when the mother is depressed
- Screening fathers should be considered
- Fathers’ emotional needs must be addressed and when indicated they also need to be referred for treatment

**Co-morbidity of Psychiatric Disorders**

- Psychiatric problems often do not occur in isolation.
- Individuals with a diagnosis of depression are at higher risk for developing a personality disorder (Enfoux et al., 2013)
- When depression is successfully treated, a co-morbid diagnosis makes it difficult to experience the benefits of treatment
- 79% of individuals diagnosed with a psychiatric disorder have more than one disorder (Kessler et al., 1994)

**Bipolar Disorder**

**Prevalence and Onset**
- **Prevalence:** up to 10% of perinatal women
- **Onset:** Pregnancy through 4 weeks postpartum. Manic or hypomanic episode lasting 4 days or more.
- Women without known history of Bipolar Disorder can be misdiagnosed with Major Depressive Disorder, causing risk of inappropriate medication triggering a manic episode.

**Symptoms**
- Abnormally and persistently elevated, expansive, or irritable mood, including increased goal-directed activity or energy
- 3 or more symptoms:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative or pressured speech
  - Flight of ideas or racing thoughts
  - Distractibility
  - Increase in goal directed activity or physical agitation
  - Excessive involvement in risky behavior

**Case: Bipolar Disorder**

*Justine:* I have to say, I sort of loved my manic episode at the time, but I have come to realize that the results can be devastating. It started a few weeks after my baby was born. I thought to myself, “I don’t know why other women say this is so hard, I have all the energy in the world.” I didn’t need to sleep at all, so it wasn’t a big deal that the baby was up a lot at night. I was so productive, creating art, cleaning the house, doing exercise videos. I felt like I could do anything. I wanted my baby to have everything she deserved, so I went to the store and bought a thousand dollars of baby clothes, toys to last her through preschool, everything I thought she could possibly want. Just as suddenly as it began, it crashed, and I felt the deepest and most despairing depression that I could imagine. I couldn’t get out of bed, I could barely talk. I was on a rollercoaster that I didn’t know how to get off of.
Postpartum Depression & Anxiety

- 59.8% of women with PPD had co-morbid anxiety (Clark, et al., 2014)
- Can be confusing for woman or providers if only looking for depressive symptoms
- Anxiety, particularly panic and fears/obsessions about the care and safety of the baby, may be initially reported as more distressing by women than depressed mood (Matthey et al., 2003)
- In a community sample receiving a preventive intervention to promote postpartum well-being, nearly equivalent rates of depression only and co-morbid depression and anxiety were found among first time mothers. Matthey et al., 2003

Symptoms of Anxiety

- Excessive worry
- Difficulty controlling the worry
- Restlessness or feeling keyed up
- Fatigue
- Difficulty concentrating or "mind going blank"
- Irritability
- Muscle tension
- Sleep disturbance

Postpartum Onset Anxiety Disorders

- Panic Disorder
- Postpartum Obsessive/Compulsive Disorder
- Posttraumatic Stress Disorder

(See Handout)

Features of a Panic Attack

- A sudden period of intense fear or discomfort
- Abrupt development of physical symptoms: heart racing, sweating, shaking, shortness of breath, feeling of choking, chest pain, nausea, dizziness
- Often accompanied by fear of dying or going crazy

Postpartum OCD

- Recurrent, persistent thoughts or images, often of harming the baby
  - Experienced as intrusive and range from mildly to severely distressing (Abramowitz et al., 2006)
  - Not necessarily associated with increased risk of harm
  - Unwanted and inconsistent with the person’s typical personality or behavior
  - Individuals may worry about sharing their obsessions out of shame or due to fear of having their baby taken away (Barr & Beck, 2008)
  - This worry may lead to challenges with caregiving and avoidance of the infant (Wenzel, 2011)
- Still need to discuss, decrease stress, and create a safety plan

Case Example: Obsessive Compulsive Disorder

Theresa: A few weeks after my baby was born, I began to get awful images of him being harmed. Once, when I was folding laundry, I got an image of my baby suffocating in the laundry basket. I couldn’t do laundry after that, because what if I didn’t know and my baby was in there? I also couldn’t give him baths, because all I could think of was him slipping under the water and drowning. Although I didn’t think I would ever really hurt my baby son, I never trusted myself alone with him. I was terrified I would "snap" and actually carry out one of these scary thoughts.
4. Impulsivity in at least 2 areas that are self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)

2. Unstable intense relationships, characterized by alternating btw. Idealization and devaluation, a lack of real commitment to sustained relationships, or marked impulsivity.

1. Frantic efforts to avoid real or imagined abandonment

DSM V Criteria: A pattern of unstable interpersonal relationships, self-image, and affects, and marked impulsivity.

- Avoidance of stimuli that might trigger flashbacks
- Birth time (3:32 pm) every day may be traumatic
- May avoid driving near the hospital of birth
- This is a problem if multiple appointments for child
- Birthday trigger
- May check out for birthdays or experience severe anxiety

PTSD Symptoms

- Recurrent, involuntary and intrusive distressing memories of the traumatic event
- Flashbacks
- Recurrent nightmares revisiting the traumatic event
- Anxiety related to remembering the event
- Distorted or exaggerated negative beliefs about oneself, the event, or others
- Persistent negative emotional state (guilt, shame, fear, anger)
- Emotional detachment or numbing
- Exaggerated startle response

Postpartum Depression and Borderline Personality Disorder

- What mental health issues do you see most often in the mothers you work with?
- How do they impact the mother and her sense of herself as a parent?
- How do they impact her interactions with her baby?

Case: Postpartum PTSD

Theresa: I had so many dreams for the birth experience that I wanted, and did everything that I could to prepare. Instead, of getting the birth that I’d hoped for, it became a nightmare. As the labor got longer and stalled out, more and more medical interventions were needed. It was all happening so fast and I felt terrorized and vulnerable. I thought I had already dealt with the abuse in my childhood. It seemed that all the years of therapy were a waste of time and money. Since the birth, I keep having flashbacks and nightmares. They feel so real — like it’s happening over and over again. I can’t leave my baby alone for a minute, even with my husband. I get the sick feeling that I can’t even trust him. Whenever anyone asks me how the birth went, I just shut down, and when they say ‘at least your baby is healthy ’ I feel so full of rage. I even resent my baby sometimes, even though I know it’s irrational, because she is the one who put me through that horrible experience.

Case Example: Borderline Personality Disorder

Tracy: It’s just me and my baby at home. I can’t really count on anyone else when it comes down to it. Her dad is around once in while, we’re pretty on and off. Sometimes I get so mad at him I can’t see straight and I tell him to get out of my life. Then he leaves and I feel so alone that I text and call until I can get him to acknowledge me and this baby he should be responsible for. My Delia, she is my sunshine though. There is no one in the world that makes me feel loved and important like she does. Although when she’s crying and won’t stop and I don’t know what to do, those are some of my darkest hours. And she’s starting to crawl away and get into things, and she’ll give me these sassy looks sometimes like she thinks she doesn’t have to listen to me. Sometimes I know I can do anything I put my mind to, and sometimes I feel like the worst mother in the world. Once in a while, when I feel really dark and overwhelmed I cut myself, it helps me get through when all I really want to do is disappear.
Possible Impact of PPD on Parenting

- Depressed moms more often match negative affective/behavioral states and less often match positive affective/behavioral states of their infants (Eidelman et al., 2009; Feld, Mayes, & Roth, 1995; Murray, Fiori-Cowley, Hooper, & Cooper, 2000).
- Mothers experiencing either depression or anxiety more often demonstrate lower maternal sensitivity and social engagement with their infants (Eidelman et al., 2009; Murray, Fiori-Cowley, Hooper, & Cooper, 2000).
- Depressed mothers hold more negative views of their interactions with their infants, and show more anger in interactions with their infants than non-depressed mothers (Weinberg & Tronick, 1998).
- Mothers report more parenting stress and less mother-infant bonding during depressive episodes (Field, Zahn, Motl, & Ruber, 2006).

Quality of Maternal Care of in the Context of Depression

- Mothers experiencing depression have been characterized in their interactions with their infants as either: Withdrawn, Under-involved or Intrusive, Controlling.
- This is not true of all mothers who are experiencing depression. Some mothers are able to be sensitive and responsive to their babies’ cues despite being depressed.

Bi-Directional Effects in Depressed Mother-Infant Interactions

- Infants imitate a variety of adult facial expressions as early as 2-3 weeks after birth.
- Mother’s depressed mood may induce a depressed state in the infant.
- Infant’s subsequent distress and unresponsiveness are likely to maintain and perhaps increase the severity of the mother’s depression.

Early Relationships and Emotion Regulation

- Experience of positive emotion helps infants to organize their experience.
- Infant-caregiver relationships provide the context for the socialization of emotion regulation - particularly in the context of face-to-face interactions.

Consequences of maternal depression for infant/child development and problems in regulation

Still Face Video
Physiologic and Behavioral Correlates of Infants of Depressed Mothers

- Less orienting behavior
- More depressed behavior
- More stressed behaviors
- More indeterminant sleep
- Right frontal EEG activation
- Lower Vagal tone
- Higher norepinephrine levels
- Higher cortisol levels

Profile of dysregulation

(National Institute of Child Health and Human Development, 1997)

The cumulative effect of depression in combination with other parental risks to healthy parenting such as poverty, substance abuse, domestic violence, or prior trauma is even greater than depression alone.

(Knitzer et al. 2008)

Consequences of PPD for Infant Development and Behavior

- Infants of depressed mothers show less interest, more anger and sadness, and more distress than infants of non-depressed mothers (National Institute of Child Health and Human Development, 1997; Taveras & Reiss, 2008; Murray & Kugih, Infant Development, 2010).
- Clinical observations of infants: sober, sad or flat affect, regulation difficulties, poor attention & eye contact, fewer vocalizations, and limited exploration of the environment (Bennett et al., Journal of the American Academy of Child & Adolescent Psychiatry, 2000).

Mechanisms by which Maternal Depression May Affect Infant/Child Development

- Exposure to symptoms
- Alterations in parenting
- Changes in family structure or functioning
- Genetic factors
- Interaction of genetic and environmental factors
- Interaction of depression and correlated factors

(Davis, Pediatrics, 2014)

Detrimental Effects of Depression on an Infant’s Health Can Start Before Birth

- Biopsychological data suggest that women’s affective states during pregnancy—specifically depression, anxiety, and elevated life stress—are associated with alterations in the neurobiological substrate of the fetus’ emerging affect regulation system (Bergner, March, & Weisz, 2007).
- Mechanisms of depression and anxiety make show both biological abnormalities suggesting that maternal psychological distress during pregnancy may have negative effects on the fetus. Maternal depression may be linked to greater fetal activity during the second and third trimesters and decreased behavioral responsivity during late gestation (Green, Spruyt, Johnson, & Kuyper, 2008).

Infants of Mothers with Postpartum Depression

- Maternal depression during the first year of life has been found to:
  - Contribute to risk for developmental delays and disturbances in young children (Trone, Gold, & Zuckerman, 2013).
  - Lower levels of mental and motor development and more insecure attachment in infants at 1 year of age (Green, 2003).

(National Institute of Child Health and Human Development, 1997)
Toddlers and Preschoolers of Mothers who experiences PPD

- Toddlers show more dysregulated aggression and heightened emotionality (Bennett, Cunningham, Lindert, & Radeke-Yarrow, 2006).
- PPD may increase the likelihood of later childhood behavioral problems (Austin, Richter, & Hetherington, 1986; Brennen & Richter, 2007; Yarrow, McInerney, & Todd, 2009).

Impact of Maternal Depression Across Childhood

- Significant associations were found between maternal depression and children's:
  - Negative affect
  - Internalizing problems
  - Externalizing problems
  - General psychopathology
- The younger a child is when exposed to maternal depression, the more likely the child is to develop psychopathology.

Impact of Maternal Depression on Father-Child Relationship

- Maternal depression is associated with paternal depression and higher parental stress. The mother's feelings about her relationship with her baby are associated with father-infant interactions (Cummings & Davies, 1994).
- For the first 6 months postpartum, fathers are very involved in their infants' lives to compensate for the mothers' lack of involvement due to her depressive symptoms. However, if the mother's depressive symptoms persisted to 12 months postpartum, paternal involvement in the infant's lives declined.

Chronicity of a Mother's Depression and Child Development & Behavior at 3 Years of Age

- Women who have experienced chronic depressive symptoms display less sensitivity when observed playing with their children from infancy through 3 years.
- Children of mothers who reported chronic depressive symptoms performed more poorly on measures of cognitive-linguistic, cooperation, and social behaviors at 36 months.
- However, maternal sensitivity moderated outcomes—mothers who experience depression but are able to be sensitive and responsive to their children are less likely to experience developmental delays and disruptions at 36 months. Important implications for therapeutic and supportive interventions. (Avan & Edward, 2011)

Theoretical Model of the Relationship between Maternal Depression and Child Outcomes

- Parental characteristics
  - Maternal Depression
  - Parent-Child Relationship
  - Marital Functioning
- Child characteristics
- Child development

Paternal Postnatal Depression

- 5-10% of fathers experience postnatal depression
- Having a partner with elevated depressive symptoms and poor partner relationships are correlated with paternal postnatal depression (Douglas, For, Rikkers, & Milgrom, 2011).
- Parenting distress, quality of marital relationship, and perceived parenting efficacy are all associated with paternal postnatal depression (Wee, Wee, & Ser, 2013). Paternal depression is associated with paternal postnatal depression (Wee, Wee, & Ser, 2013).
- Fathers may experience feelings of powerlessness, loss of control, conflict between family and work, and lack of social support (Jacob, Goel, & Palmer, 2001).
- Fathers experiencing depression may be more withdrawn, less verbal with their infants, and less behaviorally stimulating when interacting with their infants (Sethna, Murphy, New, Psychogiou, & Devault, 2015).
Moderating Factors that May Mitigate Risks to Infants

- Course/timing of depression—Chronicity
- Mother’s degree of sensitivity in parent-child interactions
- Mother's personality, co-morbid conditions & relationship history
- Length of maternity leave
- Availability of father/other caregivers
- Characteristics of the child—temperament & gender


Research on PPDs Impact on Child Outcomes is Equivocal

- Several studies show a lack of association between PPD and Infant/Child Outcomes (Klein, et al., 2011; Oman, et al., 1998)
- Some studies show association for only boys (Eckert, L. & Weiskopf, D. 2012; Wang, et al., 1993)
- Further research needed that separates out factors such as socio-economic status, environmental risk factors, maternal symptomatology, consistent definition of chronic depression, consistent time points of assessment (Plante, et al., 2012)

Additional Risk with other Mental Health Disorders

- Anxiety Disorders
  - May show characteristics of an ‘overinvolved’ parent (Möller, Majdanzic, & Bögels, 2015)
- Obsessive-Compulsive Disorder
  - May be less sensitive in their interactions with their infant and be less confident in their parenting (Challacombe, et al., 2016)
- Borderline Personality Disorder
  - May have difficulty seeing their infant as a separate individual as well as having empathy with their infant
  - May be less sensitive and positive in their mother-infant interactions (Oei, Leste, Moore, Larman, & Yell, 2014)

The Trauma Lens

- Consider what the child has been exposed to
- Consider what the parent has been exposed to
- It is the experience of the event, not that event itself, that is traumatizing
- If we don’t acknowledge trauma, we end up chasing behaviors and limiting possibilities for change
- The behavioral and emotional adaptations one makes to cope with trauma are brilliant and adaptive, and personally costly
- If you don’t ask, they won’t tell
- What is not integrated is repeated

The Trauma Lens

Types of Trauma Exposure

- Community Violence
- Complex Trauma (Multiple or Prolonged Events)
- Domestic Violence
- Early Childhood Trauma (age 0-6)
- Medical Trauma
- Natural Disasters
- Neglect
- Physical Abuse
- Refugee and War Zone Trauma
- School Violence
- Sexual Abuse
- Terrorism
- Traumatic Grief

(The National Child Traumatic Stress Network website, 2015)
Maternal Attachment, Trauma History and Quality of Mother-Infant Relationships

- Greater Unresolved Trauma and Fear of Loss (AAI)
  - Less improvement in maternal caregiving quality
  - Less improvement in infant dysregulation & irritability following treatment
- Unresolved Trauma and Fear of Loss
  - Important moderator of treatment efficacy for further study
  - Suggests this aspect of maternal state of mind may be an important port of entry for intervention
- Clinical experience also shows early loss among women experiencing PPD seems to impede their capacity to recognize and contain their anxiety and anger and respond sensitively & consistently to their infants. (Clark et al. 2008)

Trauma History & Mother-Infant Interactions

- Mothers with childhood abuse and neglect histories may have more difficulties bonding with their infants (Muzik et al., 2013)
- Mothers with childhood physical and sexual abuse histories may be more likely to be intrusive toward their infants (Moeller, Biringen, & Poustka, 2007)
- Mothers with childhood trauma histories may have a more neutral affect toward their infants (Judd et al., 2016)

Screening with the Edinburgh Postnatal Depression Scale

- 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

Media Attention and Stigma

- Highly publicized tragedies can help raise awareness among physicians and health care providers
- May lead to an increase in early identification and treatment
- Media often does not distinguish psychotic features – labels all symptoms as “postpartum depression”
- May increase stigma of women suffering from PPD
- May decrease likelihood of asking for help - fear that others will think they would hurt their children

Media Attention and Removing Stigma

- Helpful to have women like Brook Shields and Marie Osmond who are admired in our culture disclose their experience with PPD
- Decreases stigma
- Validates women’s experience
Screening as Part of an Ongoing Conversation

- You are in a prime position to observe Mothers over time
- Screen during pregnancy – 23% of women diagnosed with PPD had sx. that started during pregnancy
- During pregnancy, also assess mother’s risk for developing perinatal depression (focus on previous history or family history of mood disorder, family support, life stressors)
- Start a dialogue about risk and symptoms of perinatal depression early to engage her in looking with you at the issue
- “Prevention planning” together if risk is elevated -- put supports in place early

Screening Allows You To...

- Have an ongoing conversation about mental health and emotional well-being over time
- Look together at relationship history and current relationships
- Engage her in looking with you at the experience/issue
- “Prevention planning” together if risk is elevated – put supports in place early

Supportive Communication

- Listening is a skillful, active intervention
  - Understanding must precede action
- Don’t underestimate the healing power of supportive listening & empathy for mother
- Don’t assume mother has others in her life to provide this type of emotional support

“People will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

~ Maya Angelou

Essential Characteristics of a Supportive Relationship (Norcross & Wampold 2011)

- The Therapeutic Relationship
  - “A partnership between two allies working in a trusting relationship toward a mutual goal.”
  - It is the client’s perception of this relationship that facilitates positive change
- Hope
  - The optimism that things will improve
- Attention
  - Openly acknowledging a problem and focusing on it together

Corrective Relational Experience

- With Infant Mental Health Provider
  - Consistency and predictability
  - Rupture/Repair
  - Compassionate interactions
- With Oneself
  - Holding self in mind
  - Self acceptance and understanding
- With Their Child
  - Becoming the “protective shield”
  - Seeing their child’s value
  - Understanding their child’s motivations, needs and fears
Opportunities in Infant Mental Health Provider Relationship

- Consistency
- Presence/showing up
- Slowing down (stepping out of crisis, pausing, dropping in)
- Awareness of triggers/reactions
- Meaning of child’s behavior

Screening Can Also Offer…

- Awareness of own reactions and compassion for self (FAN: Mindful Self-Regulation)
- Not just a cognitive telling of story, but getting in touch with emotional experience
- “What was not remembered was the associated affective experience” ~Selma Fraiberg
- Getting in touch with felt experience is most important for not repeating abuse

Screening with the EPDS

- Most widely used screening tool
- Well researched and validated in many countries
- Cutoff score of 9 to cast the net wide
- Optimal screening points are after two weeks and within the first three months.

EPDS Screening Frequency

- Pregnancy – once per trimester
- Postpartum – once between 2 wks and 60 days
- Repeated screening is beneficial as a woman’s experience can change rapidly over the course of the postpartum year
- Ideal postpartum schedule: 1, 3, 6, 9, 12 mos.
- Conduct screening even if already receiving mental health services

EPDS Across Settings

- In our work together, I’d really like to be able to talk about how you are feeling, your sense of well-being and how I can best support you
- May be different levels of trust in different settings
- What was the outcome of that screening? Were any referrals made?

Creating a Safe Space in the Home

- Respectfully structure the environment
  - Ask to turn off TV or loud music
  - Ask for cell phones to be put away
- Boundaries and Privacy
  - Ask who is home (may not see someone in another room)
  - Schedule sensitive visits in Program Office (eg. ACES interview) – without kids or program support for childcare
  - Model respect for privacy and ask if there is a private place to talk
Introducing the EPDS

- Let your client know that you use this in your visits with all mothers, at the same points in time
- Communicate that you value this assessment as a way of looking together with her at her emotional experience during pregnancy/postpartum time
- Responses should be about only the past week
- Let her know that after she takes a few moments to fill it out, you will talk about it together

Discussing Screening Results

- “Your answers indicate that you have been experiencing some symptoms of depression or anxiety. How does that fit with what you’ve been feeling? I’d like to talk with you about the items and see what types of support might be most helpful.”
- “Your score is not in the range for likely clinical depression, does that fit with what you have been experiencing? Are there any kinds of additional support that you feel might be helpful?”

Discussing Screening Results

- Go through each question that the woman has endorsed and use these as discussion starters
  - “You marked ___ could you tell me more about that? Could you tell me about a time when you felt that way?”
- Always check the last item - thoughts of harming herself
- Gather history about any previous mental health issues she may have experienced, and of family history of depression, anxiety, or other mental health issues.

Providing Referrals

- Mental health parity/insurance
  - Mental health treatment reimbursed at same rate as physical healthcare
- Become familiar with mental health providers with specific training in perinatal mood and anxiety disorders
  - Maternal Child Health Hotline – www.referweb.net/mchh
- Be prepared to assist with finding transportation and childcare options for mothers to receive a mental health evaluation, diagnosis and treatment
- Offer to go together to first appointment

Barriers to Referral Follow Up

- Stigma of mental illness
- Media portrayal - sensationalizing
  - Andrea Yates (often do not differentiate between severe postpartum depression and postpartum psychosis)
- Fear of mental health or child welfare system
- Minimizing or normalizing symptoms
- Influence of motherhood myths
- Lack of energy or motivation are symptoms of depression

Involve Her Partner and Family

- Ask Mother about discussing results with her partner or family member
- Wonder with partner about his/her concerns
- Provide and review DHS More than Just the Blues Brochure
  - PSI website (www.postpartum.net) and Federal booklet mchb.hrsa.gov/pregnancyandbeyond/depression/index.htm
  - info and video for Dads/Partners and Family Members
Provider Barriers

• Boundaries/Scope of Practice
  - You are not responsible for managing or treating symptoms of PPD, but you can facilitate a connection to a mental health professional and provide a supportive relationship

• First make sure the discomfort felt with the mother/family is not your own discomfort
  - Reflect on your own feelings and preconceptions about mental health
  - Practice your responses. Learn from each encounter.

The Role of the PNCC/Home Visitor in Safety Assessment

• This module is focused on assessing risk for self-harm and potential risk of harm to baby by the client and not specifically on safety issues related to domestic violence, neighborhood violence or assessing risk to your own safety although these are important considerations to be aware of.

• It is important to be aware of risk factors and to raise the issue of safety in conversation with your client and to look together at these concerns.

• This requires your willingness to ask difficult questions of your client regarding any thoughts of self-harm and safety concerns for her baby/child(en)
  - Suicidal thoughts – assess for safety to self and baby
  - If necessary, to develop a safety plan together
  - Offer community based referrals and resources

Know Your Agency Policy

• Be familiar with agency and state policies regarding risk of harm to self or baby/child, reporting of abuse or neglect, reporting of significant in-utero risk to fetus.

• Know who to go to for back-up and support (e.g. supervisor, team discussions, reflective supervision)

• Document questions asked and action taken

Addressing Safety Concerns

• Many of you are using the Edinburgh Postnatal Depression Scale (EPDS) to screen for depressive symptoms in your clients

• In reviewing her responses to the questions on this screener with your client, this is an ideal time to ask about thoughts of self-harm

• Her response on EPDS question #10, “The thought of harming myself has occurred to me”, any response other than “0”, “Never” requires further assessment.

Determination of Risk

Suicide Risk Assessment

Protective Factors

Risk Factors

Modifiable Risk Factors

Specific Suicide Inquiry

Risk Level:
Low, Med., High
**Calm in Crisis**

- When asking about and hearing the mother’s thoughts of harm to herself and/or her baby, this can trigger feelings of being overwhelmed or scared.
- Focus on slowing down – breathe slowly and deeply, speak slowly and calmly, ask for the details.
- By staying calm you can best be a reassuring presence and help the mother not feel shamed by admitting these thoughts.

**Suicide Warning Signs**

- Talking about wanting to die or to kill oneself.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain, wanting this feeling to be over.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Displaying extreme mood swings.
- Looking for a way to kill oneself, such as searching online or buying a gun.

(Adapted from the US Department of Health and Human Services, 2015)

**Ask the Questions…**

- **Are you feeling hopeless about the present or future?**
  - **YES, ASK**
    - “Have you had thoughts of ending your life?”
  - **YES, ASK**
    - “When did you have these thoughts and do you have a plan of how would do this?”
    - “Have you ever made a suicide attempt in the past?”

Follow up with questions about specifics regarding prior attempt(s) as to method and lethality as previous history predicts future behavior.

**Talking with Mothers About Safety**

- Reassure your client that you are asking about safety because you want her to feel safe & secure.
- Use a matter-of-fact approach.
- Openers:
  - “Some women who are feeling depressed or overwhelmed have thoughts of hurting themselves. I am wondering if you ever have these kinds of thoughts?”
  - “How about with your baby? Do you ever worry about his safety or that you might hurt him?”
  - “Tell me more about these thoughts….”
- Normalize that it may be difficult to talk about these thoughts or fears.
- Provide emergency resource information, even if it is not needed now.

**Procedures for Assessment of Suicide Risk**

- Although there is much information to gather, there are no shortcuts to suicide assessment.
- Risk assessment requires directness, intentional questioning, and careful listening.
- The essential qualities of a supportive relationship including empathy, active listening, reflecting the client's words and re-statements are important in suicide assessment and intervention.
- Information that is gathered during this assessment should be documented including direct quotes.

**Safety Assessment – Important Questions to Ask**

- Active vs. Passive Thoughts?
- Hopelessness
  - “Do you have a plan?” (specific time/place/method)
  - Lethality/actual risk of plan? (ask for details)
  - “Do you have Means/Access?”
  - “Do you intend to carry out this plan? (intent)”
  - “What has prevented you making an attempt so far?”
  - “Have you made any previous attempts?” (when, level of risk, state of mind at the time/similarity to now, who if anyone was available to help?)
  - “Who knows about your feelings and plan?” (Stressors/social supports)
  - “Are you willing to make a safety plan?”
Factors that May Increase Risk

- Current ideation, intent, plan, access to means
- Previous suicide attempt or attempts
- Alcohol/Substance use
- Current or previous history of psychiatric diagnosis
- Impulsivity and poor self control
- Hopelessness
- Recent losses – physical, financial, personal
- Recent discharge from a psychiatric unit
- History of suicide
- History of abuse (physical, sexual, emotional)
- Co-morbid health problems, especially a recently diagnosed problem or worsening symptoms
- Access to weapons
- LGBTQ orientation

Protective Factors

- Pregnancy (May not be as protective as previously thought (Lindahl, 2005))
- Children in the home, except among women with postpartum psychosis
- Sense of responsibility to family
- Reality testing ability
- Life satisfaction
- Positive social support
- Spirituality
- Coping skills
- Problem-solving skills
- Positive therapeutic relationship

When Risk is Identified But is Not Imminent

- **Emergent: Acute/Urgent Care Services**
  - Contact family doctor, local mental health crisis line
  - **Document** risk level and safety plan to reduce risk
  - 1-800.SUICIDE (1-800-784-2433): The National Hopeline Network: Transfers you to a suicide helpline in your county.
  - 1-800-PPD-MOMS (1-800-773-6667): Crisis line that is specifically for women in the postpartum period; Provides short assessment with referral to either a peer counselor or connects woman to local crisis center.
  - **Self-harm:** Consider evaluation for psychotherapy and/or psychiatric.

Safety Assessment – Harm to Infant

- Determine the nature of the mother’s thoughts
  - **Lower risk/anxious thoughts:** fear of “something” terrible happening to baby; fear of anger towards one’s baby when tired or overwhelmed
  - **Ego-dystonic:** “I feel awful about having those thoughts, would never act on them”
  - Ruminations – repetitive thoughts or images that are hard to shake, but with the above tone
- **Higher risk:** Psychotic thought processes (e.g., command hallucinations telling the woman to harm her child(ren), religiosity)
- History: impulsivity, aggression/violence, history of being abused, previous diagnoses including personality disorders or psychotic episode
- Triggers/cop ing strategies? Who knows? Who can we talk with about helping you feel safer?

Determine the Most Appropriate Action to Ensure Immediate Safety

- **Emergent (Immediate Danger):** Ensure that your client is brought to an **Emergency Room**, is talking with a **Local Mental Health Crisis Unit**, or is seen in **PNCC**
  - (Many counties provide a mobile crisis unit to assess and make safety determinations. To find out whether there is a Mobile Crisis Unit in your county see http://www.phawisconsin.org/Data/Sites/1/media/pls/pls_crislines)

  - **Higher and Imminent Danger:**
    - Active talk of hurting herself or her baby
    - A plan and means
    - Psychosis, bizarre thinking patterns, command hallucinations, delusions
    - Little or no sleep for several days
    - Mother lives alone or is alone
    - Hopelessness

PNCC/Home Visitor Role in Creating a Safety Plan

- **Create a written safety plan with detailed steps of what the woman you are working with can do and who to contact if she experiencing thoughts of harm**
- **Involve a supportive person in the home**
- **Removal of “Means”**
- **Identification of Triggers**
- **Identification of Coping Strategies**
- **Assist with arranging for Supervision of Mother and/or baby**
- **Plan for Support/Respite**
- **Plan for who to contact if ideation worsens**
- Emergency Options – 911, Emergency
  - **Children:** 1-800-SUICIDE (1-800-784-2433) or 1-800-273-TALK
  - **Emergencies:** Call local County Crisis Center or school suicide prevention line
**PNCC/Home Visitor Role in Reducing Risk**

- Inform and involve a family member or someone close and reliable to the client
- Care coordination—request consent for release of information and contact primary care or mental health provider to insure barriers to access and follow-up care
- Limit access to means of self-harm or suicide
- Schedule a follow-up appointment within 48 hours
- Increase contact and make a commitment to help the client through the crisis

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**Questions to consider in your follow-up discussion with Mom...**

1. What do you want to know more about? (follow up on specific items especially suicidal ideation)

2. Wonder with Mom about how her mood might impact her experience of mothering and her time with her baby?

3. What supportive interventions might you offer (individual, mother-baby and family)?

4. What referral opportunities might you suggest (mental health evaluation and treatment, mother-baby groups, child care or respite care)?

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**Engage Mother in Assessing her Relationship with her Infant**

- Use of video to look together across situations

- Reassure her that this is just a “snapshot of one point in time” and that you will wonder with her about how it is “alike” or “different” from how things usually go

- Collaborative assessment and goal setting
**Identifying Areas of Strengths and Concern**

Maternal positive affective involvement, sensitivity, & responsiveness

Maternal negative affect and behavior

Maternal insensitivity, inconsistency and anxiety

**Identifying Areas of Strength and Concern**

Infant Positive Affect, Communicative and Social Skills

Infant Quality of Play, Interest and Attentional Skills

Infant Dysregulation and Irritability

**Identifying Areas of Strength and Concern**

Dyadic Mutuality and Reciprocity

Dyadic Tension

**History of Being Parented**

• “Ghosts” & “Angels” in the Nursery
  \(\text{(Fraiberg et al., 1980; Lieberman, 2007)}\)

• Representations of attachment relationships

**Video Replay with Mother**

Engage Mother in wondering about:

- Meaning of this child and his/her behavior to her
- Her ability to read her child’s cues
- Reinforcement value of the child
- Her experience of being parented including Relational/Trauma history
- Her sense of competence and confidence in the parenting role
- Dyad’s capacity for enjoyment

**Treatments for Women with Postpartum Depression**

• Medication
• Individual Psychotherapy
• Group Psychotherapy
• Mother-Infant/Family Psychotherapy
Use of Medication During Pregnancy and Breastfeeding

- Risks and benefits to the mother and infant must be weighed carefully when considering medication.
- The importance of capable parenting which is compromised by depression and the benefits of breastfeeding should be weighed in the decision making process.
- Treatment duration >120 days reduces risk of recurrence.

American Academy of Pediatrics, 2002
Waxer, 2002, APR
ACOG 2010

Mother-Infant Therapy Group
(M-ITG) – 3 components

- **Mothers’ Therapy Group**: Reduce social isolation and provide social support; increase cognitive and interpersonal coping strategies; examine internal working models of relationships.
- **Infant Developmental Therapy Group**: Increase infant’s affective and behavior regulation and developmental functioning through positive affective involvement, responsive caregiving, and developmental stimulation.
- **Mother-Infant Dyadic Therapy Group**: Promote sensitivity and responsiveness to infant’s cues and sense of competence in the mothering role.

Mother-Infant Therapy Group for Mothers with PPD and their Infants (M-ITG)

- **Initial Family Session**
- **Video Replay Session and Mother-Infant Relationship Goal Setting**
- **Group Sessions**
  - Session #1: Expecting and Adjusting to a Baby
  - Session #2: Ambivalence: Love and Anger
  - Session #3: Coping with Depression and Coping
  - Session #4: How to Nurture Yourself and Enjoy Play
  - Session #5: Depression and Coping in the Family (Partners/Significant others)
  - Session #6: Promoting Security, Safety, and Health
  - Session #7: Communication and Problem Solving (Partners/significant others)
  - Session #8: Self-Esteem and Competence
  - Session #9: Individuality, Mutuality, and Relationships
  - Session #10: Preventing Recurrence of Depression: Addressing Mothers’ and Children’s Needs Now and in the Future
  - Session #11: Promoting Security, Safety, and Health
  - Session #12: Wrap-up and Looking Ahead

Final Family Session

Goals for Mothers

- To recognize interpersonal, intrapsychic, and cognitive patterns contributing to depressive symptoms.
- To provide strategies for reducing depressive symptoms.
- To participate in a group process designed to broaden social support which reduces the sense of isolation.

Mother-Infant Therapy Group for Mothers with PPD and their Infants (M-ITG)

- Exploration of family of origin issues: engage mother in “wondering” about the impact of her own experience of being parented on her relationship with her infant (internal working model of relationships).
- Peer support: use group process based on the integrated theoretical perspective and additional strategies such as role play, group and home activities, and resource materials.

The need for a relational approach to address the needs of the:

- Mother
- Infant
- Father and other family members

(Fraiberg, Stern, Lieberman, Tronick, Siegel)
Goals for Infants

- To promote feelings of safety, security, and effectance in interactions with others
- To increase their capacity to demonstrate a greater interest in and responsiveness to others
- To increase their regulation, range, and differentiation of affect
- To support and encourage developmental skills

Mother-Infant Dyadic Relationship Goals

- To promote affective attunement and responsive caregiving, exposure to wider range of affective expressions, and developmental stimulation
- To promote reciprocity between mother and infant
- To enhance the mother’s feelings of competence in the parenting role

Infant Developmental Therapy Group Strategies

Infant Caregiver:
- Modulates intense affect and provides containment
- Facilitates exploration of the environment
- Follows infant’s lead in play
- Responds sensitively to infant’s cues and needs
- Expresses positive affect
- Mirror and verbalize feeling states observed

Mother-Infant Dyadic Group Strategies

- Check in with mother on her emotional state
- Physically position dyads to promote eye contact, nurturing physical contact and reading of cues
- Wonder along with mother about how things may be going for her infant by amplifying infant’s attempts to communicate (e.g. speak for the infant)

Mother-Infant Dyadic Group Strategies

- Respect, extend and support mother’s initiatives
- Amplify, reinforce, and encourage mother’s positive affect and behavior

Therapeutic Mother-Father-Infant Group Sessions for Husbands/Partners

- Identify partner’s needs
- Provide peer support
- Demystify depression and promote empathy for the mother
- Work on communication and problem-solving in their relationship
- Emphasise their role in supporting infant development

Participation in Selected Group Sessions
A Relational Approach to Treating Maternal Depression: Empirical Findings

- Mothers in the Mother-Infant Therapy Group reported significantly fewer depressive symptoms, and experienced their infants as more reinforcing following 12 weeks of treatment than did the depressed women in the Waiting List Control Group. They also were rated as exhibiting more positive affective involvement in interactions with their infants following treatment than did mothers in the Waiting List Control Group.

- Mother-Infant Therapy Group and Individual Interpersonal Therapy were both effective in reducing maternal depressive symptoms and increasing the quality of mother-infant relationships following a 12 week treatment program.

Clark, Tluczek, & Wenzel, 2003
Clark, Tluczek & Brown, 2008

Therapeutic Approaches with Mother-Infant Dyads

- Depression alone
  - Increase positive affect
  - Increase sensitivity and responsiveness
- Depression and Anxiety
  - Reduce stress
  - Increase feelings of competence
- Depression and OCPD
  - Address sources of anxiety
  - Reduce perfectionist tendencies and need for control
- Depression and BPD
  - Provide structure, clear treatment goals
  - Increase distress tolerance and emotion regulation capacities
  - Increase ability to see child as a separate individual

What you can do to support family relationships in the context of maternal depression

- Be attuned to the stressed and depressed mother
- Wonder with her how she is doing
- Listen, validate and provide hope
- Interact with a range of affect, especially positive
- Address the questions and concerns of the woman’s partner and enlist his/her assistance in supporting her instrumentally and emotionally
Support the Mother/Infant Relationship

- Suggest using part of visit to “just be with” baby in one-to-one ‘special time’
- Developmentally appropriate play
- Soothing activities (massage, cuddling/lullaby)
- Singing/music
- Making daily tasks playful
- Face-to-face interaction
- Smiling, even when you don’t feel like it
- When fussy, vocalizing or reaching out, wonder with mom about what baby is needing or trying to communicate
- Support/reinforce her positive efforts toward reading baby’s cues & providing support

(Clark, 2006)

Support Mother-Infant Relationship

- “Speak for baby” to highlight cues & reactions to mom’s efforts
- Amplify baby’s initiatives toward mom
- Model gentle handling & responsivity toward baby
- Non-judgmental developmental guidance
- Dispel myths about spoiling young babies

(Clark, 2006)

Supporting Good Mental Health

- Slow down pace
- Realistic expectations around the house, food, cleaning or socializing
- Allow time for bonding

Realistic Expectations

- Take time to nurture self
- Treat emotional needs with respect
- Make time to connect with others

Allow time for Nurturing Oneself

- During breaks, do some things you like to do, not just the things you have to do
- Schedule brief breaks like at work – even a short time can feel reviving

Take Breaks
**Sleep**

- Prioritize sleep and aim for recommended amounts (7-9 hours for an adult)
- Support developing a routine to relax before bed
- Discuss strategies for maximizing nighttime sleep

**Nutrition**

- Increase the number of healthy foods consumed each day
- Limit junk food and caffeine

**Exercise/Daily Movement**

- Provide information about connections between exercise and feelings of well-being
- Improves sleep
- Can reduce symptoms of depression
- Can reduce anxiety

**Spirituality**

- Explore the use of meditation, prayer, or reflection as a calming and centering time
- Spiritual community can be an important source of support

**The Tripod of Mindful Self Regulation**

- Openness
  - Letting go of judgments and prior expectations
- Objectivity
  - A thought, feeling, or memory is an activity of the mind, not the totality of who someone is
- Observation
  - See more clearly by becoming an observer

*Siegel, D. & Shahmoon Shanok, R. (2010)*

**Activate Circle of Support**

- Mom’s Groups
- Dads/Significant Others*
- Family Members*
- Friends
- Neighbors
- Co-Workers
- Faith Communities

*Assess support/conflict ratio
Reflection…

What can I imagine taking with me into my work with women struggling with depression and their infants, young children and families?