

THE KNOCK-ON EFFECTS OF POST NATAL DEPRESSION: WHY IT IS VITAL TO INTERVENE UNTIL THE DEPRESSION IS ADEQUATELY RESOLVED

Compiled by Joanne Zagnoev (Clinical Psychologist)

There is a deluge of scientific literature that alerts us to the deleterious effects of Post Natal Depression (PND) on child development. PND often results in negative emotional, behavioural, cognitive and physical health outcomes in the child of the mother with PND. PND has been shown to be associated with:

- Disrupted attachment in the mother-infant dyad which is in turn associated with
 - Low emotional resilience (diminished capacity to cope with stress)
 - Language delays
 - Childhood and adolescent depression and/or anxiety
 - ADHD and aggression (especially in boys)

- Where there are other children in the family, PND in the mother is shown to be associated with:
 - Lack of parental support in school
 - Lack of capacity to set limits and appropriate boundaries
 - Inappropriately punitive discipline
 - A family environment that is stressful, unpredictable and often neglectful.

- Further, PND can have a significantly deleterious effect on the marriage dyad which in turn increases the levels of stress in the home and can lead to divorce.

- PND in the mother has been shown to be correlated to an increase of occurrence of PND in fathers – the levels of stress in the mother disrupt the fathers' emotional balance. This can affect the fathers' capacity to work optimally which can create long term health risks for the entire family.

Research also indicates that:

- Early diagnosis and intervention is essential.
- A combination of medication, individual psychotherapy and group support achieves the most successful remediation.
- Earlier intervention is strongly correlated with a better outcome.

Based on my 20 years of experience in treating women with PND, I am absolutely convinced that:

- In cases of severe PND, it is absolutely impossible to treat PND in 12 sessions. Rather, it is necessary for a mother with PND to be in therapy for a minimum of six months, but preferably for a year.
- Treating PND is a highly specialized field. Treatment cannot in any way regress the client who can ill afford a decrease in her emotional resources. The appropriate treatment involves psycho-education, support and cognitive behavioural intervention. I am strongly opposed to depth therapy until the mother has achieved adequate improvement in her mental health to warrant the pain of looking into her past. I am equally convinced that once Mother is stabilized, a course of psychodynamic therapy in which she can understand how her past has informed her present is highly protective against another episode of depression. Again, this points to the need for extended therapy benefits.
- Ending therapy prematurely is traumatic for the mother – the weekly session offers her a holding environment that enhances her capacity to adequately “hold” her baby (where the term “holding” has both literal and metaphoric meanings).
- There are mothers where the cause of the PND is largely personality based. In order to maintain the mental health of these mothers, which in turn protects her family against the ill effects of mental disease, it is necessary to engage her in therapy once a week for many years. While this seems to be an unnecessary intervention, I am convinced that in keeping Mom well, the

overall medical costs the family will incur will be far lower than if such a Mom is left unsupported.

My driving belief is that mothers are the centre of the home. A functional, emotionally healthy mother protects her family against stress through optimism, humour, effective organizational skills, and good leadership. As soon as the mother's capacity to contain and direct her family is compromised, the stress levels of each member of the family increase. It is almost unnecessary given the dearth of literature to this effect to comment on the devastating effects of stress on every aspect of health.

I am of the firm opinion that it makes good business sense to intervene speedily and effectively in the event of a member of your medical aid having PND. Additionally, adequate treatment that will protect both the mother and her family (husband included) needs to be long term. Post natal depression cannot be treated in 12 sessions. And for most women, given the new terms of cover regarding affiliated care, there are no available sessions.

In conclusion, PND is a serious mental illness that has long term deleterious effects on the entire family. These effects are not short term. Rather, they can be long term and incur great cost. A simple example would be the case of a mother who experiences PND after the birth of her third child. Many depressed mothers are too ill to see to their children's basic health needs. Nutrition is often neglected, and chores such as seeing to children brushing their teeth are too difficult and are neglected. The family is then beset with years of expensive dental work to correct the lack of care during the years that teeth form.

I have absolutely no problem with xxxxxx being a profitable business and have no expectation that you run a non-profit community service. In accordance with this corporate model, and against the backdrop of the realms of research on the deleterious long term effects of PND, I recommend that you reassess the long term costs to you of not intervening effectively in the treatment of your clients with PND.

SUGGESTIONS:

1. Increase cover for psychotherapy sessions for women with PND!!!
2. Train those medical professionals who necessarily see new mothers to identify PND expeditiously. The most obvious port of call is the Gynaes and Paeds. I give numerous training workshops around the country on the diagnosis and treatment of PND and almost none of the above mentioned professionals attend. Early diagnosis expedites treatment which in turn reduces treatment time.
3. Offer specialized training to psychotherapists who would then be certified as PND trained therapists. This could be done together with PNDSA.
4. As part of your allocated broader community investment, to partner government in training primary care health providers to diagnose PND and make the appropriate referrals for treatment.

RESEARCH THAT SUPPORTS THE ABOVE CONCLUSIONS:

1. Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health

Background. Much attention has been paid to the problem of postpartum depression in women. However, there is some indication that men also experience depression after the birth of a child, and that paternal depression is linked to maternal depression.

Aims. The purpose of this integrative review was to examine current knowledge about postpartum depression in fathers. Specific aims were (1) to examine the incidence of paternal depression in the first year after the birth of a child, (2) to identify the characteristics and predictors of paternal postpartum depression, (3) to describe the relationship between maternal and paternal postpartum depression, and (4) to discuss the influence of paternal depression on the family and infant.

Methods. A literature search from 1980 to 2002 was carried out using the CINAHL, PsychInfo, and Medline electronic databases. Twenty research studies were identified that included incidence rates of paternal depression during the first year postpartum. These were further examined and synthesized regarding onset, severity, duration, and predictors of paternal depressive symptoms, and for information about the relationship between maternal and paternal depression.

Findings. During the first postpartum year, the incidence of paternal depression ranged from 1.2% to 25.5% in community samples, and from 24% to 50% among men whose partners were experiencing postpartum depression. Maternal depression was identified as the strongest predictor of paternal depression during the postpartum period. The implications of parental depression for family health were discussed.

Conclusions. Postpartum depression in men is a significant problem. The strong correlation of paternal postpartum depression with maternal postpartum depression has important implications for family health and well-being. Consideration of postpartum depression in fathers as well as mothers, and consideration of co-occurrence of depression in couples, is an important next step in research and practice involving childbearing families

2. Effects of postnatal depression on children's adjustment to school. Teacher's reports.

Abstract

BACKGROUND Little is known of the behavioural adjustment of children of postnatally depressed mothers. Previous studies have relied on maternal reports, and have produced inconsistent findings.

METHOD In a prospective, longitudinal study of the five-year-old children of a community sample of postnatally depressed and well women, evidence was collected concerning the children's adjustment in the context of school, teachers being asked to complete questionnaires after the children had finished their first term.

RESULTS Family social class and the child's gender had the most pervasive influences on adjustment. However, both postnatal and recent maternal depression were associated with significantly raised levels of child disturbance, particularly among boys and those from lower social class families.

CONCLUSIONS The findings indicate a persistent effect of postnatal depression on child adjustment. They highlight the need for resources devoted to supporting mothers of young children and particularly routine screening and treatment for postnatal mood disorder.

3. Maternal Depression Affects Language Development in Babies

Oct. 8, 2012 — Maternal depression and a common class of antidepressants can alter a crucial period of language development in babies, according to a new study by researchers at the University of British Columbia, Harvard University and the Child & Family Research Institute (CFRI) at BC Children's Hospital.

Published today in the *Proceedings of the National Academy of Sciences*, the study finds that treatment of maternal depression with serotonin reuptake inhibitors (SRIs) can accelerate babies' ability to attune to the sounds and sights of their native language, while maternal depression untreated by SRIs may prolong the period of tuning.

"This study is among the first to show how maternal depression and its treatment can change the timing of language development in babies," says Prof. Janet Werker of UBC's Dept. of Psychology, the study's senior author. "At this point, we do not know if accelerating or delaying these milestones in development has lasting consequences on later language acquisition, or if alternate developmental pathways exist. We aim to explore these and other important questions in future studies."

The study followed three groups of mothers -- one being treated for depression with SRIs, one with depression not taking antidepressants and one with no symptoms of depression. By measuring changes in heart rate and eye movement to sounds and video images of native and non-native languages, the researchers calculated the language development of babies at three intervals, including six and 10 months of age. Researchers also studied how the heart rates of unborn babies responded to languages at the age of 36 weeks in the uterus.

"The findings highlight the importance of environmental factors on infant development and put us in a better position to support not only optimal language development in children but also maternal well-being," says Werker, who adds that treatment of maternal depression is crucial. "We also hope to explore more classes

of antidepressants to determine if they have similar or different impacts on early childhood development."

High resolution photos of Werker (reading to children) and co-author Tim Oberlander are available upon request.

Background

"These findings once again remind us that poor mental health during pregnancy is a major public health issue for mothers and their infants," says co-author Dr. Tim Oberlander, a professor of developmental pediatrics at UBC and CFRI. "Non-treatment is never an option. While some infants might be at risk, others may benefit from mother's treatment with an antidepressant during their pregnancy. At this stage we are just not sure why some but not all infants are affected in the same way. It is really important that pregnant women discuss all treatment options with their physicians or midwives."

Previous research by Werker has found that during the first months of life, babies rapidly attune to the language sounds they hear and the sights they see (movements in the face that accompany talking) of their native languages. After this foundational period of language recognition, babies begin focusing on acquiring their native tongues and effectively ignore other languages.

The current study suggests that this key developmental period -- which typically ends between the ages of eight and nine months -- can be accelerated or delayed, in some cases by several months. In another recent study, Werker has found that this development period lasts longer for babies in bilingual households than in monolingual babies, particularly for the face recognition aspects of speech.

The maternal depression and language acquisition study was co-authored by UBC post-doctoral fellow Whitney Weikum at CFRI, Tim Oberlander of CFRI, UBC's Dept. of Pediatrics and BC Children's Hospital, and Takao Hensch, a professor of neurology at Harvard University.

This program of research was funded by agencies including the Human Frontiers Research Program (HFSP), the Canadian Institutes for Advanced Research (CIFAR), the Michael Smith Foundation, and the Canadian Institutes of Health Research (CIHR), the Social Science and Humanities Research Council of Canada (SSHRC) and the Natural Sciences and Engineering Research Council of Canada (NSERC).

4. Postnatal depression

[Peter J Cooper](#), professor and [Lynne Murray](#), professor

There has been considerable recent clinical and research interest in postpartum depression. This has been largely provoked by the accumulating evidence that postnatal depression is associated with disturbances in child cognitive and emotional development.¹ This evidence, which is reviewed below, has renewed concern about the epidemiology of postnatal depression, its aetiology, methods of prediction and detection, and the most appropriate form of management.

Summary points

- Postnatal depression is associated with disturbances in the mother-infant relationship, which in turn have an adverse impact on the course of child cognitive and emotional development
- Postnatal depression affects 10% of women in the weeks immediately post partum
- There is little evidence for a biological aetiology; antenatal personal and social factors are more relevant
- Postnatal depression is commonly missed by primary care teams despite the fact that simple reliable detection procedures have been developed
- The treatment of choice in most cases of postnatal depression is counselling, which can be effectively delivered by health visitors
- There is a need to develop preventive intervention strategies

Methods

This article is based on a review of the recent research concerned with the impact of postnatal depression on child development, and the epidemiology, prediction, detection and management of the disorder. Authoritative recent reviews are cited as well as the most impressive research papers. To supplement our immediate knowledge of the literature we performed literature searches with Medline and PsychLit (1980-97) using the relevant key words (“postnatal/postpartum depression”

in conjunction with “infant/child development/outcome, epidemiology, aetiology, prediction, detection and treatment”).

Impact on parenting and child outcome

There have been several recent prospective studies of samples of women with postnatal depression and their children.¹ They indicate a definite association between the maternal mood disorder and impaired infant cognitive development. Thus, in Cambridge a community sample of children of mothers who had had postnatal depression were found to perform significantly less well on cognitive tasks at 18 months than did children of well mothers, especially the boys.^{2,3} Two London studies of more socioeconomically disadvantaged populations have found that this effect still obtained when the children were 4-5 years old.^{4,5} Poor emotional adjustment has been shown to be similarly associated with postnatal depression. Thus, most studies that have systematically examined infant attachment in the context of postnatal depression have found a raised rate of insecure attachments.^{2,6,7} There is evidence that these emotional problems persist. A follow up of the Cambridge cohort found that the 5 year old children of mothers who had had postnatal depression were significantly more likely than controls to be rated by their teachers as behaviourally disturbed.⁸ One major conclusion from these studies is that the mechanism mediating the association between postnatal depression and adverse child developmental outcome is the impaired pattern of communication occurring between the mother and her infant.¹

Impact on child development

- Cognitive development in the context of postnatal depression is adversely affected, especially among male children and socioeconomically disadvantaged groups
- The children of postnatally depressed mothers tend to have insecure attachments at 18 months, and the boys show a high level of frank behavioural disturbance at 5 years
- The adverse child outcome in the context of postnatal depression is related to disturbances in the mother-infant interactions

Treatment and the mother-infant relationship

Few studies have examined the impact of treating postnatal depression on the quality of the mother-infant relationship and child development. One controlled trial of psychological treatment found that the intervention was associated with significant improvement in maternal reports of infant problems, both immediately after treatment (four to five months post partum) and at 18 months post partum.³¹ In addition, early remission from depression, itself significantly associated with treatment, was related to a reduced rate of insecure infant attachment at 18 months. *Vicious cycle* Similar benefits have been reported in a study of health visitors' practice.²³ When training was provided to all the health visitors working in one NHS sector a cohort study was conducted, with assessments made of the health visitors' clientele both before and after the training. Treatment significantly improved both maternal mood and the quality of the mother-infant relationship.

It seems that the adverse child outcome arising in the context of postnatal depression is driven by disturbances in the mother-child relationship, which begin in the early postpartum weeks (or days). This highlights the importance of early detection and treatment by primary care teams. It also suggests that preventive interventions might prove particularly profitable.

5. Postpartum Depression Effects on Early Interactions, Parenting, and Safety Practices: A Review

[Tiffany Field](#)^{1,2}

Abstract

In this paper studies are reviewed from the last decade on postpartum depression effects on early interactions, parenting, safety practices and on early interventions. The interaction disturbances of depressed mothers and their infants appear to be universal, across different cultures and socioeconomic status groups and, include less sensitivity of the mothers and responsivity of the infants. Several caregiving activities also appear to be compromised by postpartum depression including feeding practices, most especially breastfeeding, sleep routines and well-child visits, vaccinations and safety practices. These data highlight the need for universal screening of maternal and paternal depression during the postpartum period. Early interventions reviewed here include psychotherapy and interaction coaching for the mothers, and infant massage for their infants.

The significance of continuing research on postpartum depression is highlighted by the increasing incidence of postpartum depression and some longitudinal studies that have reported long-term negative effects of postpartum depression on children's health and their social, emotional, cognitive and physical development. Statistics from large sample studies have placed postpartum depression at about 20–40% in mothers and a somewhat lower percentage in fathers ([Goodman, 2004](#); [McCoy, Beal, Shipman, Payton, Watson, 2006](#)). In these samples, similar rates of postpartum depression were noted for the mothers and fathers in families where the mother was experiencing postpartum depression symptoms.

The long-term negative outcomes, including behavioral, emotional and health problems, have been frequently attributed to disturbed mother-infant interactions, although more recent data suggest that poor parenting and safety practices are also risk factors. This paper is a review of studies from the last decade on postpartum

depression effects on early interactions, parenting and safety practices and on early interventions.

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Early Interactions

As already mentioned, researchers have attributed the long-term effects of maternal depression including behavior problems, cognitive delays and physical health problems to disturbed early interactions ([Beardslee, Versage & Gladstone, 1998](#)). In a meta-analysis of studies on the early interactions of postpartum depressed mothers, the mothers who were depressed across their infants' first 3 months of life were noted to be more irritable and hostile, to be less engaged, to exhibit less emotion and warmth and to have lower rates of play with their 3-month-old infants ([Lovejoy, Graczyk, O'Hare & Neuman, 2000](#)).

Most of the mother-infant interaction studies have focused on infants between three and six months because that seems to be the primary form of play for infants that age. Non-depressed parents are noted to engage in face-to-face interaction play behavior that features vocalizing, smiling, imitation and gameplaying ([Field, 2006](#)). These interactions, in turn, are thought to be the "playing field" for infants learning communication skills such as turntaking. Fewer of these behaviors have been noted in depressed mothers and their infants, which may contribute to their interaction disturbances ([Field, 2006](#)). The interaction disturbances of depressed mothers and their infants appear to be universal across different cultures and socioeconomic status groups. For example, less vocal and visual communication and less smiling have been noted in depressed mother-infant interactions in Switzerland ([Righetti-Veltema, Conne-Perreard, Bousquet & Manzano, 2002](#)). Similarly, in England, depressed mothers are less sensitively attuned to their infants ([Murray, Fiori-Cowley, Hooper & Cooper, 1996](#)). These early interactions disturbances have also been noted, for example, in Arabic cultures ([Eapen et al, 2005](#)) and Turkey ([Danaci et al, 2002](#)).

Depressed mothers appear to have at least two different styles of interacting including an intrusive, controlling and over-stimulating style or a withdrawn, passive and under-stimulating style ([Malphurs, Raag, Field, Pickens & Pelaez-Noqueras, 1996](#)). Postpartum depressed mothers in comparison with non-depressed mothers touch their infants less frequently and in a less affectionate manner ([Ferber,](#)

[Feldman & Makhoul, 2008](#)) and a more negative manner (e.g. rough pulling, tickling and poking) ([Fergus, Schmidh & Pickens, 1998](#) ;[Malphurs et al, 1996](#)). Infants of depressed mothers spend more time touching their own skin, which may compensate for their receiving less positive touch from their mothers ([Hentel, Beebe & Jaffe, 2000](#); [Herrera, Reissland & Shepherd, 2004](#)).

Depressed mothers also differ on their vocal behavior, including the use of longer utterances, less repetition, more negative affect, fewer explanations, suggestions and questions and fewer references to their infants' behavior ([Herrera et al, 2004](#); [Kaplan, Bachorowski & Zarlengo-Strouse, 1999](#)). Others have noted differences in the vocal timing of depressed mothers' responses to their 4-month-old infants' vocalizations ([Zlochower & Cohen, 1996](#)). In this study, the duration of switching pauses in depressed mothers was longer, more variable and less predictable than the timing mechanism of the non-depressed mothers. The authors suggested that depression may play a role in reducing synchrony in depressed mothers' and infants' interactions, affecting the mother's ability to coordinate her vocal behavior with her infant's vocalizations and non-verbal behavior. Consistent with the observation that depressed mothers have less infant-directed speech is a finding that they do not show a shorter mean length of utterance for younger versus older babies, in contrast to non-depressed mothers ([Reisslan, Shepherd & Herrera, 2003](#)). It is not surprising, then, that the infants of depressed mothers later show less expressive language and perform more poorly on measures of cognitive-linguistic functioning ([NICHD Early Child Care Research Network, 1999](#)).

In a study on a very large sample (N=5,089) of both depressed mothers and fathers, depressive symptoms were also associated with less enrichment activity with the infant including less reading, singing songs, telling stories and playing games ([Paulson, Dauber & Leiferman, 2006](#)). Mothers who were depressed were less likely to tell stories and play peek-a-boo with their infants (according to their self-report), and depressed fathers were less likely to sing songs and play with their infants. However, in another study, paternal depression did not affect at least the fathers' frequency of interactions (Lyons-Ruth et al, 2002).

Postpartum paternal depression has been noted to exacerbate maternal depression effects on later child behavior problems but only if the father has spent significant amounts of time caring for the child during infancy ([Mezulis, Hyde & Clark, 2004](#)). In addition, being exposed to a non-depressed father did not buffer the effects of

maternal depression, even if the father spent significant amounts of time with his infant.

All of these interaction activities are important for later cognitive, social, emotional and physical development ([Britto, Fuligni & Brooks-Gunn, 2002](#); [Bus, van Ijzendoorn & Pellegrini, 1995](#)). Thus, the lesser amount of time spent by depressed parents in these activities does not augur well for their infants' later development. This may be particularly true for male infants inasmuch as they are noted to have even more difficult interactions with their depressed mothers. For example, in a recent study, male infants as compared to female infants were more vulnerable to high levels of maternal depressive symptoms, and high symptom mothers and their sons had more difficult interactions ([Weinberg, Olson, Beeghly & Tronick, 2006](#)).

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Inadequate Caregiving Practices

Several caregiving activities also appear to be compromised by postpartum depression effects on the developing parenting roles including feeding practices, most especially breastfeeding, sleep routines and well-child visits and vaccinations.

These would seem to be even more basic functions of parenting, although they have received less attention than the effects of postpartum depression on mother-infant interactions.

Breastfeeding

Most studies on parenting practices have reported reduced odds of continuing breastfeeding for mothers who are postpartum depressed ([Dennis & McQueen, 2007](#); [McLearn, Minkovitz, Strobino, Marks & Hou, 2006](#)). In both of these studies, the mothers with high postpartum depression scores were significantly more likely to discontinue breastfeeding at 4 to 16 weeks postpartum and were giving the infant water, juice or cereal during that time ([McLearn et al, 2006](#); [Paulson, Dauber, & Leiferman, 2006](#)). These undesirable feeding practices may have, in turn, led to the feeding difficulties noted in infants of depressed mothers (Righett-Veltema et al, 2002).

In the [Dennis and McQueen \(2007\)](#) study, the mothers also reported being unsatisfied with breastfeeding and having experienced significant breastfeeding problems and lower levels of breastfeeding self-efficacy. Similarly, in another study based on high Edinburgh depression scores, an inverse relationship was noted

between depressive symptoms and breastfeeding at 6 weeks postpartum ([Hatton, Harrison-Hohner, Coste, Dorato, Curet & McCarron, 2005](#)), although, the inverse relationship did not continue beyond 12 weeks. In at least one study, however, depression was surprisingly not related to breastfeeding ([McCarter-Spauling & Horowitz, 2007](#)).

Sleep problems

In the same large sample study reporting undesirable practices and infant feeding problems, undesirable sleep practices and sleep problems were also noted ([McLearn et al, 2006](#)). The sleep practices associated with maternal depression included placing the infant to sleep in the prone position instead of the recommended supine position. In other samples, sleep problems included the infant sleeping in the parents' bed, being nursed to sleep, taking longer to fall asleep and waking more often and for longer periods ([Hiscock & Wake, 2001](#)). The same sleep problems were associated with high depression scores and tended to increase as depression scores increased. In still another study on disturbed sleep patterns, mothers with major depressive symptoms at 4 and 8 weeks were more likely to report that their infant cried often, woke up 3 times or more between 10pm and 6am, and received less than 6 hours of sleep in a 24 hour period during the past week ([Dennis & Ross, 2005](#)). The infants' sleep problems also did not allow the mothers to get a reasonable amount of sleep. Consistent with these findings, the mothers with high depression scores were more likely to report that they often felt tired.

Similarly, in another study, problematic sleep patterns included 1) parental disagreement regarding managing the infants' sleep; 2) the infant sleeping in the parents' room; 3) the mothers nursing the infants to sleep at the beginning of the night; and 4) the infants waking 7 nights per week ([Hatton, et al 2005](#)). In addition, the mothers who reported infant sleep problems had poor mental and physical health as compared to those not reporting sleep problems.

Healthcare

Maternal depressive symptoms have also been noted to affect children's receiving health care during infancy. In a cohort study of data collected prospectively as part of the National Evaluation of Healthy Steps for Young Children, infants whose mothers had depressive symptoms at 2–4 months had increased use of acute care later in infancy including emergency department visits in the past year ([Minkovitz, Strobino, Charfstein, Hou, Miller, Mistry & Swartz, 2005](#)). The infants of depressed mothers

also had received fewer preventive services including age-appropriate well-child visits at 12 months and up-to-date vaccinations at 24 months.

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Safety Practices

Safety practices have also been affected by maternal depression symptoms. In a secondary analysis from the Health Steps National Evaluation, interviews given at the end of infancy provided information about safety practices including using an infant car seat, having electric outlet covers, having safety latches on cabinets and having lowered the temperature on the water heater ([McLearn, et al, 2006](#)). In this sample, the mothers with depressive symptoms at 2–4 months had a reduced odds of using car seats and lowering the water heater temperature. Mothers with concurrent depressive symptoms had a reduced odds of using electric outlet covers and using safety latches. In a similar large database in England, however ([Mulvaney & Kendrick, 2006](#)), maternal depression did not appear to be related to safety practices including the safe storage of medicines, the use of smoke alarms and the safe storage of sharp objects. These discrepant findings may relate to cross-cultural differences or simply the assessment of different safety practices by the two studies.

Thoughts of Harming Infants

Thoughts of harming infants are also more frequent among depressed mothers. In one sample, 41% of depressed mothers compared to 7% of control mothers admitted to thoughts of harming their infant ([Jennings, Ross, Popper & Elmore, 1999](#)). More than half the depressed mothers had a problem with thoughts of harming their infant, fear of being alone with the infant and an inability to care for the infant.

Punishment

Mothers with depressive symptoms have also been noted to use harsh punishment ([McLearn et al, 2006](#)). Again, taken from the Healthy Steps sample, those with depressive symptoms had increased odds of using harsh punishment by slapping the child on the face or spanking the child with an object.

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Clinical Implications

The findings from these studies on early interaction problems and inadequate caregiving and safety practices have important clinical implications for pediatric

healthcare professionals. One of the implications is the need for universal screening of maternal and paternal depression by pediatricians during the postpartum period, inasmuch as pediatric professionals have frequent contact with families at that time.

Several pediatric organizations have suggested that pediatric professionals not only be involved in the universal screening but also in guidance and referrals for maternal depression treatment ([Murray et al, 1996](#)). The US Preventive Service Task Force has recommended 2-item screeners to be used by primary care professionals to detect depression symptoms ([US Preventive Services Task Force, 2002](#)). In a recent study, for example, a significant increase was noted in the detection of depression symptoms among mothers during the first postpartum year following the implementation of the universal postpartum depression screening during well-childcare visits ([Chaudron, Szilagyi, Kitzman, Wadkins & Cornwell, 2004](#)). Secondly, pediatricians are being encouraged to provide anticipatory guidance to mothers with depression symptoms, including discussions of parenting practices such as continuing breastfeeding, playing, talking and providing routines and book-reading. The screening and interventions should also be directed at depressed fathers and partners of depressed mothers.

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Behavioral Interventions

Most intervention programs for postpartum depressed mothers have focused on providing pharmaceuticals or psychotherapy for the mothers. Although the psychotherapy studies have suggested positive effects, the literature on antidepressants is mixed and generally suggests that antidepressants should not be used at least by breastfeeding mothers (see [Field, 2008](#) for a review).

In a review on the different types of psychosocial and psychological interventions for postpartum depression, several databases were searched for these kinds of interventions ([Dennis & Creedy, 2004](#)). Basically this review suggested that women who received psychosocial interventions were equally likely to develop postpartum depression as those receiving standard care. The only promising intervention in this review was intensive postpartum support by public health nurses or midwives.

Identifying mothers at-risk assisted the prevention of postpartum depression, although, surprisingly, interventions with only a postnatal component appeared to be more beneficial than interventions that also incorporated a prenatal component. In

addition, while individually-based interventions were more effective than those that were group-based, the women who received multiple-contact interventions were again, surprisingly, just as likely to experience postpartum depression as those who received a single-contact intervention.

In a study on psychotherapy to help postpartum depressed mothers interact with their infants, the depressed women were randomly assigned to interpersonal psychotherapy or to a waitlist control group ([Foreman, O'Hara, Stuart, Gorman, Larsen & Coy, 2007](#)). At 6 months, the depressed mothers were less responsive to their infants, they experienced more parenting stress, and they viewed their infants more negatively than non-depressed mothers did. The treatment only reduced parenting stress, although parenting stress was still higher in the depressed versus the non-depressed mothers. At an eighteen month follow-up, the depressed mothers who received interpersonal psychotherapy still rated their children lower on attachment security, higher on behavior problems and more negative on temperament than the children of non-depressed mothers. Thus, it would appear that treatment of the mothers' depression symptoms is not sufficient. Early interventions may need to also focus on mother-infant interactions.

Interaction coaching has been developed to help mothers improve their interaction behaviors by providing them video feedback, by giving them instructional sets such as having them imitate their infants' behavior and by using "bug-in-the-ear" second-by-second suggestions as the interactions occur (see [Field 2006](#) for a review).

These interventions have been effective with postpartum depressed mothers in several studies reviewed by [Field \(2006\)](#). A recent study by another group targeted mother-infant interactions to help parents understand and respond to their infants' behaviors with the goal of increasing positive affect in the infants ([Jung, Short, Letourneau & Andrews, 2007](#)). The intervention was carried out in 5 weekly group sessions beginning when the infant was 3 months of age. The dyads were videotaped during face-to-face interactions. Following the intervention, the infants showed more interest and joy expressions when interacting with their mothers. Even though the mothers' depression ratings did not change, the authors concluded that the intervention had helped the mothers focus on what they were doing with their infants rather than simply how they were feeling.

Finally, teaching depressed mothers to massage their infants has resulted in less irritability and fewer sleep problems in the infants and better mother-infant

interactions ([Field, Grizzle, Scafidi & Abrams, 1996](#)). The mothers' depression has also been reduced by massaging their infants ([Goldstein-Ferber, 2004](#)).

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Methodological Limitations

Many of these studies have the limitation that they used self-report measures (the CES-D and the Edinburgh Depression Scales) to assess parental depression.

Although these self-report measures are not typically used for clinical diagnoses, the self-report depression scales do reflect a range of depressive symptoms that are typically associated with the diagnosis of depression, and they are reliable measures. Further, they are cost-effective measures that could be used for universal screening to identify postpartum depressed mothers and fathers for early interventions.

The measures used for assessing parent caregiving activities and safety practices were also completed by self-report. Although parent reports have been correlated with observational measures in some studies, the self-reports are typically completed by the mothers, not the fathers. This may, in part, explain the data on paternal depression effects. More detailed parenting style and behavior observations may be needed and on both mothers and fathers in future studies.

Finally, it is not clear how the data from these studies have been affected by confounding interventions such as the anticipatory guidance intervention designed by the American Academy of Pediatrics. Inasmuch as most parents are being seen by pediatricians, which would suggest that they are receiving some anticipatory guidance, this may be a confounding factor in the assessment of the parents' behaviors.

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Summary

This paper reviewed studies from the last decade on postpartum depression effects on early interactions, parenting, and safety practices, and on early interventions. The interaction disturbances of depressed mothers and their infants appear to be universal across different cultures and socioeconomic status groups and include less sensitivity of the mothers and responsiveness of the infants. Several caregiving activities also appear to be compromised by postpartum depression including feeding practices, most especially breastfeeding, sleep routines and well child visits,

vaccinations and safety practices. These data highlight the need for universal screening of maternal and paternal depression during the postpartum period. Early interventions reviewed here include psychotherapy and interaction coaching for the mothers and infant massage for their infants. Further observational research and studies on educational and therapeutic interventions are needed.

6. Impact of Postnatal Depression

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Women who experience depression after having a child are known to experience higher levels of distress in terms of symptoms and relationship difficulties (particularly marital) than non-childbearing women with depression. PND can have long term effects on the mother, her infant and children and on the couple and family relationships.

The nature of these effects will depend on the number and severity of the symptoms and the length of time that the mother's depression goes unidentified or inadequately treated. With early identification and skilled treatment and support most women with PND will recover, their recovery can mean an enhancement of their life skills and emotional development, and the re-building of relationships.

Impact on the mother:

As with general depression PND can impact enormously on the mother's physical well being - the changes in her diet, sleep and activity levels can result in her being less well nourished, exhausted and overly or less active than usual. Combined with ongoing depression and high levels of anxiety this will in turn reduce the body's immunity and ability to fight infection. Eventually the emotional distress of depression and anxiety may be expressed in increasing physical symptoms that might be felt as pain, headaches, chest pain or difficulty breathing.

There are also long term implications for the mother's mental health as a result of PND, particularly if there is inadequate treatment. Pitt (1968, as reported by Milgrom) found that without treatment 30% of women experiencing severe PND are still very

unwell one year after the baby. Fifty percent of women with PND can continue to experience symptoms 2 years after diagnosis. In addition, women who have experienced PND are twice as likely to experience future depression over a five-year period, compared to women who have experienced depression unrelated to childbirth.

Impact on the partner:

Living with a woman experiencing PND is difficult. Partners need a lot of support too and are known to be at risk of developing depression themselves. They often feel confused, lost and helpless. They can be the target of their partner's distress and irritability as she attempts to make sense of what is happening to her. Not only is he expected to stop being the 'cause' of her distress, he is expected to know how and when to listen to her, support her, and to know exactly the right things to say.

The relationship between the parents may become very stressed or even threatened by the conflict created by the mother's distress and intense needs within the relationship and the father's struggles to know how to support his partner. Important decisions about the relationship should ideally be postponed until the depression has improved. "It may not be that a difficult relationship causes depression; rather that depression can cause problems in the marital relationship.

The partner's workload can increase enormously as he attempts to continue working to provide their single income but he may also need to take on more of the household work and the care of the children if his partner has not been able to manage during the day. In addition to this he may be feeling very anxious about how his partner is coping at home with the baby, especially if she rings during the day, and also trying to manage his own distress and frustrations as to why his partner is not getting better. He may be feeling very isolated and lonely.

It is important that partners be included by the support services and health professionals treating women with PND. Partners are much more supportive if they understand what the problem is and what they can do to help, as well as needing support and encouragement themselves. For more information have a look at the fact sheet *When Your Partner has PND*.

Impact on the mother-infant relationship:

While not so for all women with PND, PND can interfere with the behavioral and emotional interactions that are now recognized as being necessary for a successful mother-infant relationship. Mothers with depression might be less sensitive to the needs of their babies, might feel less close to their baby or could be less responsive to the baby's communications. As a result the mother may be withdrawn or overly intrusive with the baby as she tries to care for him/her.

The mother's feelings towards her baby may come and go as the symptoms of depression fluctuate. Sometimes the feelings make the mother feel numb, as if she has nothing to give. Sometimes the mother may feel overwhelmed or trapped by the demands of the baby and resent the baby. Or she may not be able to relax or switch off from the needs of the baby, needing to be constantly vigilant about his/her well being. These things are not reflections of the mother but rather the symptoms of depression.

Women experiencing PND benefit from gentle reminders and frequent reassurances that this will not last forever. The mother needs to be encouraged to make eye contact with her baby and to try to make faces and noises in interaction with him/her, even if she doesn't feel like it. The baby's father and other family members need to understand the baby's need for interaction and to continue to do so as the mother builds her ability to do this.

In the meantime it is important that the mother's efforts to care for her baby are supported, rather than taken over by others helping to care for her baby or other children. Small gains and huge efforts to interact with or care for her baby must be acknowledged and encouraged by her partner and family members, reinforcing her special role as the baby's mother.

Many women with PND have experienced these difficulties and have found, with recovery, that positive relationships and feelings have been re-established.

Impact on Infant Development:

Difficulties in mother-infant interaction over extended periods of time (especially untreated long term PND) may compromise many aspects of the infant's development - increased fussiness or withdrawal, brain pathways development, cognitive and social skills.

Parent-child relationships may be damaged due to the mother's withdrawal or volatility, parental conflicts or inconsistent parenting. Untreated PND can impact on the child's later cognitive and language development, social competence, behavioral and parenting difficulties.

Impact on family relationships:

The impact of PND on family relationships could be viewed as having an enormous ripple effect. Parents, siblings and extended family members are all affected by the presence of PND. Often a woman with PND will not tell members of her family about how she feels because of the response she feels she may receive. It takes an enormous amount of energy to hide PND but usually family members can identify that the woman has changed, is not her normal self or doesn't seem to be coping or enjoying life. These changes in the mother can cause conflict in her relationships that she struggles to deal with.

Efforts by family members to enquire about or to support the mother may come across as critical or intrusive, especially if the mother is feeling highly sensitive or distressed. Some family members ask directly or research symptoms of PND and present these to the mother. Many family members make contact with PANDA on behalf of the mother to seek information and strategies to help her, for example how to be patient, encouraging and to listen unconditionally to the mother's feelings or concerns.

For some family members PND may trigger strong responses of distress or concern because of their own associations with depression or parenting. Others may not understand PND and may not be open to learning more about it. Most family members wish only that the mother would be happy and find it hard to understand why she can't snap out of it.

If the PND continues untreated these impacts can worsen over time and the toll it takes on family members increases. Stress and depression may be an outcome of these ongoing impacts and it may be important for the family members to seek support and treatment for themselves.

Risks of Postnatal Depression

If PND remains unidentified, untreated or is moderately severe the woman may be experiencing some thoughts and behaviour that present a risk to her or her baby. For

most women their thoughts of harm or suicide are fleeting and represent a desire for their pain and distress to go away, for example a desire to go away and not come back.

It is vital to assess what thoughts she has been having and if she is concerned for herself, particularly when these fleeting thoughts take on greater detail or become more prevalent. It can be particularly difficult to share these thoughts as they are scary and distressing to acknowledge. Family and partners may not know how to respond to these feelings and thoughts.

The areas of risk that need to be assessed should include:

Suicide - thoughts, details and plans to take her own life

Self Harm - behaviour that puts herself at risk physically (self mutilation) or the use of alcohol or drugs as a form of self medication, eg bingeing

Harm to baby - this may be due to neglect and difficulty caring for the baby, physical abuse as a result of the mother's inability to cope or emotional harm due to limited bonding and attachment. Infanticide is a rare and devastating outcome of PND.

Mental Health risks - the woman may not be acknowledging the degree of severity of her symptoms and therefore not seeking or accepting treatment, or if she may be deteriorating rapidly. Her well being can be put at increased risk.

7. **Journal of Abnormal Psychology, Vol 100(2)**, May 1991, 151-155. doi: [10.1037/0021-843X.100.2.151](https://doi.org/10.1037/0021-843X.100.2.151)

Abstract

1. The consequences of maternal postpartum depression for mothers and children were investigated in a 4½-yr follow-up study, which included 70 of 99 women who had participated in an earlier study of postpartum depression. Information about maternal adjustment and depression during the follow-up period and child adjustment at age 4½ yrs was obtained. Women who had experienced a postpartum depression were predicted to be at increased risk for subsequent depression and poor adjustment of their child. Postpartum depression was directly related to subsequent depression but not child problems. Later depression was related to child problems at 4½ yrs. **We concluded that postpartum depression may increase risk for later maternal depression and in turn increases risk for child behavior problems. Intervening with women who have experienced a postpartum depression may reduce likelihood of future depressions and child behavior problems.** (PsycINFO Database Record (c) 2012 APA, all rights reserved)

8. Kids of moms who had postpartum depression more likely to be short by age 5

(CBS News) It's no secret that your height may be influenced by your parents. But, new research suggests a mother's emotional state after giving birth may also contribute to a child's height.

A study found that kids of mothers who had postpartum depression were more likely to be shorter than their classmates.

"Mothers with higher levels of depressive symptoms in the first year postpartum were more likely to have children who were shorter in stature in preschool and kindergarten age," study author Dr. Pamela Surkan, assistant professor at the Johns Hopkins Bloomberg School of Public Health, in Baltimore, said to [HealthDay](#). "This study points to another reason why it's really important for mothers to get help for depression during the postpartum period."

Postpartum depression involves moderate to severe depression after a woman gives birth, occurring most often within the first three months after delivery, according to the [National Institutes of Health \(NIH\)](#). Feelings of anxiety, irritation, tearfulness, and restlessness are common in the week or two after pregnancy. These feelings, sometimes called the "baby blues," almost always go away shortly after without treatment but postpartum depression may occur when the feelings do not fade away or when signs of depression start 1 or more months after childbirth.

For the new study, published Sept. 10 in [Pediatrics](#), researchers reviewed nationally representative birth data on more than 6,500 kids to determine if mom's depression nine months after giving birth negatively affected a child's growth after his or her third birthday.>

They found that children of moms with mild to moderate or severe depression were 40 percent more likely to have a child below the tenth percentile in height by the time he or she was 4 years old and 48 percent more likely by the time the child turned 5 years old. Maternal depression was not tied to deficits in children's weight at these ages.

The study does not show cause and effect, but postpartum depression has been linked to a shorter duration of breast-feeding, attachment issues along and increased stress in kids, all of which all could affect growth. The researchers say early

detection and treatment of postpartum depression with efforts focusing on prevention may prevent delays in child growth among young kids.

Surkan noted to HealthDay that if you have short parents, genetically you're supposed to be in the tenth percentile in height and that is normal.

"But if the reason you're in the 10th percentile is because you lacked nutrition or because you had a number of illnesses over the course of your early childhood that weren't treated properly, that is a problem," she said.

New mothers with postpartum depression should get help right away, according to the NIH. They are encouraged to ask their partner, family and friends to help with the baby's needs in the home, to be open with their feelings, make time to go out and visit friends or spend alone time with their partner, get lots of rest and not try to do too much or be perfect.

Treatments may include a combination of medication and or therapy.

Commenting on the study to [NBCNews.com](https://www.nbcnews.com), Dr. Andrew Leuchter, professor of psychiatry at UCLA, said, "It's more evidence that depression in the mom can have negative health effects on the kids. So it really underlines the urgency of treating depression in these mothers so the kids don't suffer."

[The NIH has more on postpartum depression.](#)

9. What Pediatricians Need To Know About Postpartum Depression

By [Katherine Stone](#) January 22, 2013 [Leave a Comment](#)

While the American Academy of Pediatrics suggests pediatricians screen for postpartum depression, not all of them do. I'm happy to have Natasha Sriraman, MD, MPH, FAAP, IBCLC as our guest today. Dr. Sriraman is a board-certified pediatrician in Norfolk, VA. Today she explains what pediatricians need to know about PPD, and why they should screen.

Postpartum depression is the most common and serious postpartum condition, affecting 10% to 20% of mothers within the first year of childbirth. ([Gierdingen](#))

Studies have found that up to 50% of women with PPD go undiagnosed. Postpartum depression has been shown to be more common among women who are disadvantaged and is highly prevalent (25%) in low-income, black mothers.

([Chaudron](#))

The American Academy of Pediatrics (AAP) recommends that pediatricians screen mothers at infant well-child visits. Every year more than 400,000 infants are born to mothers who are depressed, making PPD the most underdiagnosed obstetric complication in America.

Most women typically only have 1-2 postpartum visits with their obstetricians, where depression screening may not always occur. For low-income women, particularly minorities, the risk of undiagnosed and untreated depression is especially high because of below-average rates of postpartum follow-up visits with obstetricians.

([Earls](#))

Since a pediatrician can see a child up to six times within the first six months of life, they are probably in the best position to identify mothers suffering from postpartum depression. The nature and longevity of the pediatrician-patient relationship, coupled with the frequency of visits, allows mothers to develop a certain level of trust with their child's pediatrician, making it more likely that the mother will speak to her pediatrician about other issues that may be affecting the child's environment, health

and well-being. The health status of a child is directly linked to and affected by the mother's perceived sense of health, both mental and physical.

The adverse effects of postpartum depression are far-reaching. It can cause family dysfunction, prevent effective mother-baby dyad bonding, cause early cessation of breastfeeding, and can adversely affect infant growth and brain development.

Postpartum depression can cause mothers parents to neglect anticipatory guidance and health care advice, including safety and preventive measures such as car seat and home safety measures. Depressed mothers are more likely to engage in less healthy feeding and sleep practices with their infant. Infants living in an environment with a depressed mother are likely to have delays in development, impaired social interactions and may be less likely to respond to interventional therapies. Mothers who are depressed are less likely to read to, cuddle with, and interact with their child, leading to deficits in language acquisition. Infants of depressed mothers show less engagement and eye contact with their mother and are at risk for failure to thrive, attachment disorder, and development delay. ([Earls, Minkovitz](#))

Depressed mothers are less likely to breastfeed, nurse for shorter durations, and have more negative emotions and experiences toward breastfeeding. New mothers experiencing breastfeeding difficulties may be more likely to be suffering from PPD, highlighting the importance of screening. ([Watkins](#)) In addition, children of depressed mothers are less likely to attend well-child visits, have their children receive timely vaccinations, and use the emergency department more often.

Despite AAP recommendations that pediatricians should screen new mothers for postpartum depression at 1, 2, and 6 months ([Bright Futures](#)), only a small percentage of pediatricians are currently screening for PPD. Reasons include lack of time, education, and confidence with respect to mental health issues; inadequate reimbursement; lack of knowledge of resources; and fear of liability. ([Olson, Chaudron, Leiferman](#)) These barriers are deterrents to screening within pediatric practice. Validated instruments must be used and not replaced with informal assessment, which does not comply with standard of care and is inefficient.

We struggle with the number of topics that need to be addressed at each well child visit in a short time. Although pediatricians can bill for maternal depression screening, many pediatricians note that inadequate knowledge, skills, and responsibility for follow-up care and liability are deterrents to screening. We receive no training in maternal depression during residency training. Since the mother is not

the pediatrician's patient, the provider may feel awkward and legally vulnerable. However, many pediatricians are open to modifying their practice and to interventions to increase their knowledge about maternal depression. There are many educational methods available to pediatricians to improve their knowledge and self-efficacy in recognizing PPD. (Leiferman)

Before starting screening for PPD in a pediatric office, systems must be in place to allow for proper referral, appropriate case management, and follow-up.

Understandably, many pediatricians are fearful to open 'Pandora's Box.'

Pediatricians are often unaware of mental health resources in the community. Social workers are a key component of the referral process. If a social worker isn't available on site, collaborative working relationships need to be established between the pediatric practice and mental health providers in the community. Medical staff should be trained on how to do mental health referrals, especially for those screens that are positive and/or the mother is positive for suicidal ideation. If the mother declines an immediate referral or speaking with the social worker, the pediatrician can provide her with a list of print and online resources, local and national, so that she can access help when she's ready. The pediatrician can ask to speak to a family member who might be able to offer some support. The pediatrician should schedule close follow-up to monitor any negative effects on the mother-baby dyad. (Gjerdingen, Bright Futures)

Maternal depression is an important public health issue and can be associated with comorbid conditions. If left untreated, PPD can worsen, adversely affecting the mother, her child(ren), and the family. All of these things can negatively affect the growth, development, and health of the infant.

The outpatient pediatric clinical setting may be the best opportunity to screen, identify, and refer a depressed mother for timely and appropriate mental health therapy. Taking care of a mother's mental health needs is a professionally rewarding opportunity because we will be making a long-term, positive effect on our most vulnerable pediatric population. ([Sriraman](#))

10. Reducing Maternal Depression and Its Impact on Young Children

Toward a Responsive Early Childhood Policy Framework

Authors: Jane Knitzer, Suzanne Theberge, and [Kay Johnson](#)

Publication Date: January 2008

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Executive Summary

Maternal depression is a significant risk factor affecting the well-being and school readiness of young children. Low-income mothers of young children experience particularly high levels of depression, often in combination with other risk factors. This policy brief provides an overview of why it is so important to address maternal depression as a central part of the effort to ensure that *all* young children enter school ready to succeed. It highlights:

- what research says about the impact of maternal depression on young children, particularly infants and toddlers, and how prevalent maternal depression is;
- examples of community and programmatic strategies to reduce maternal depression and prevent negative cognitive, social emotional and behavioral impacts on young children;
- key barriers to focusing more attention to maternal depression in policies to promote healthy early child development and school readiness;
- state efforts to address policy barriers and craft more appropriate policy responses; and
- recommendations.

Depression is increasingly recognized as major worldwide public health issue. It has a negative impact on all aspects of an individual's life – work and family – and can even lead to suicide. Typically, depression is discussed as an adult problem affecting women or men, and increasingly, it is recognized as a significant problem for children.¹ But far too rarely is depression, particularly maternal depression, considered through a lens that focuses on how it affects parenting and child outcomes, particularly for young children; how often it occurs in combination with

other parental risks, like post-traumatic stress disorder; and what kinds of strategies can prevent negative consequences for parents, for their parenting and for their young children.

Maternal depression, alone, or in combination with other risks, can pose serious but typically unrecognized barriers to healthy early development and school readiness, particularly for low-income young children.

- The negative effects of maternal depression on children's health and development can start before birth.[2](#)
- Maternal depression can impair critical early relationships.[3](#)
- Maternal depression can impair parental safety and health management (such as breastfeeding, safety practices, preventive health measures, or managing chronic health conditions).[4](#)
- The cumulative impact of depression in combination with other parental risks to healthy parenting (such as poverty, substance abuse, domestic violence, or prior trauma) is even greater.[5](#)
- Depression in other caregivers (fathers, grandparents, child care providers) can also impact the early development of young children.[6](#)

Prevalence Data on Maternal Depression

- Approximately 12 percent of all women experience depression in a given year.[7](#)
- For low-income women, the estimated prevalence doubles to at least 25 percent.[8](#)
- Estimated rates of depression among pregnant and postpartum and parenting women in general range from 5 to 25 percent.[9](#)
- Low-income mothers of young children, pregnant and parenting teens report depressive symptoms in the 40 to 60 percent range.
- — Over half the mothers (52%) in a study of 17 Early Head Start programs reported depressive symptoms.[10](#)

— Another study found that an average of 40 percent of young mothers at community pediatric health centers screened positive for depressive symptoms (site specific rates ranged from 33% to 59%).¹¹

— Studies of women participating in state welfare-to-work programs indicate that depression and elevated levels of depressive symptoms range from 35-58 percent.¹²

Recommendations

This brief profiles several emerging efforts to target depression in parents of young children, including such strategies as:

- screening and follow-up for women, typically in ob/gyn or pediatric practices;
- targeted interventions to reduce maternal depression and improve early parenting in early childhood programs such as home-visiting and Early Head Start Programs; and
- promoting awareness about the impact of maternal depression and what to do about it for the general public, low-income communities, and early childhood and health practitioners.

This brief also makes a series of policy recommendations for communities, states, and the federal government. Addressing and targeting resources to maternal depression as a barrier to early healthy development and early school success is complex undertaking that will require the involvement of programs, community leaders, state policymakers and legislators and families and researchers at local and state levels, as well as some national leadership. To move this agenda forward, below is a set of strategic actions for those at the local, state and federal levels.

At the local level, communities can:

- conduct a community scan to assess local capacity for screening and following-up for pregnant women and parents of babies and young children and to identify how existing resources are used;
- engage local funders, including community foundations, to develop a strategic plan and implementation steps to help local early childhood programs test

and/or replicate evidence-based, effective family focused practices to address maternal depression and its impact on young children;

- assess and strengthen community capacity to address depression in fathers as well as mothers, and in others who care for young children on a daily basis, whether in families or in child care settings;
- engage leaders of low-income communities in designing and evaluating public awareness campaigns and culturally and linguistically responsive outreach and program strategies;
- document disparities and implement strategies to track and improve access to culturally and linguistically responsive instructions; and
- combine public and private dollars to support early childhood mental health consultants to work with home-visitors and other caregivers.

At the state level, public officials and advocates can:

- use ECCS grants to help health care providers and systems implement a developmental multi-generational family health/mental health perspective, including attention to prenatal depression and related risks as part of implementing the medical/dental home vision;
- dedicate a staff person to coordinating interagency screening, prevention and treatment efforts to address depression through a family lens, paralleling positions that have been created for to coordinate cross-agency activities around women's health or HIV/AIDS;
- develop a cross-agency strategic action plan to reduce maternal depression and its impact on young children that identifies what each system will do separately and together, such as:
 - build on medical home initiatives and perinatal screening initiatives, making sure there is appropriate follow-up treatment;
 - support cross-training efforts for primary care providers in health and early care and learning settings;
 - expand early childhood mental health strategies to include attention to depression in staff and families;

— provide support to expand access to screening and follow-up treatment for pregnant and parenting mothers through both health practices and early childhood programs;

— train and identify mental health consultants with documented expertise in dealing with depression through a family lens to work with pediatricians, early care and learning programs and women’s health agencies; and

— embed attention to depression beyond health and early childhood systems and programs (especially TANF, marriage initiatives, WIC, child welfare, etc.) in developing program initiatives, regulations, etc.

- Maximize the use of Medicaid to prevent and treat depression and related risk factors in the context of promoting healthy early child development, such as:
- — use Medicaid waivers (or if that is prohibited, state funds) to extend health insurance coverage to mothers with young children at least to the eligibility levels that the children are covered for the first two years following birth or use the child’s access to Medicaid to cover parents;
- — promote public awareness campaigns and educational materials that show the links between early school success and addressing maternal depression.

At the federal level federal officials, including Congress can:

- ensure that Medicaid facilitates, rather than impedes, states’ ability to pay for depression reduction and prevention strategies that are designed to improve outcomes for young children;
- provide incentives to the states to cover parents of young children through Medicaid up to 200 percent of the poverty level to ensure access to treatment for depression as well as health conditions that impair parenting;
- create a federal interagency work group, either through legislation or executive order, including health, mental health and children’s agencies that can develop a strategic action plan, and potentially pool funds to support state efforts to design comprehensive approaches to prevent and reduce parental depression and improve outcomes in young children;

- embed attention to depression beyond health and early childhood systems and programs (especially TANF, marriage initiatives, child welfare, etc.) in developing program initiatives, regulations, etc.; and
 - develop a strategic NIH research agenda that includes support to develop and test a range of interventions to address maternal depression, promote more effective parenting strategies and improve outcomes for young children, particularly for low income
 - women experiencing depression along with other risk factors.
-

Conclusion

This issue brief calls for policymakers to include much more serious attention to maternal depression as part of the larger efforts across the country to improve healthy developmental and school-readiness outcomes in young children.

The argument is simple: particularly for low-income children, maternal depression is a known barrier to ensuring that young children experience the kinds of relationships that will facilitate their success in the early school years. Investing in treatment and support for one generation will promote healthy development and school readiness for the next. Addressing maternal depression through a parenting and early childhood lens is in effect a “two-fer”: it can help parents, but importantly, it will also pay off for their children, both in the short term and in the longer term. There are tough barriers, particularly fiscal barriers, to creating family focused interventions. It requires a framework shift that provides public incentives for a family-focused, namely multi-generational, culturally responsive, approach that brings together resources from multiple public systems. There is also a critical role as a catalyst and seeder of initiatives for private philanthropy.

The real message from this brief is clear. While there is much more to be known, we already have enough evidence about effective approaches to address a damaging condition that ripples throughout a family and a community, with lifelong implications for everyone it touches. We simply cannot afford not to respond with resources and commitment.