Educational & Developmental Intervention Services (EDIS) Personnel Development

KIT

Keeping In Touch

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UNDERSTANDING DEPRESSION

Resource Article

An assumption in the helping field is that having a child with special needs negatively impacts parental mental health. Lambrenos, Weindling, Calam, and Cox considered this premise in their 1996 article, *The effect of a child's disability on mother's mental health*. The researchers were specifically interested in the following hypotheses: (1) when a disability is predicted in preterm infants more mothers will become depressed than when it is not, or in comparison with mothers of healthy term infants; (2) rates of maternal depression will be higher when their children have a physical disability; (3) mothers living with high levels of psychosocial adversity will be more depressed than mothers living in less stressful conditions; (4) predicted or emerging disability combined with psychosocial adversity will result in more mothers becoming depressed; and (5) the rates of depression in mothers whose children receive early physiotherapy intervention will be lower than for mothers whose children are at risk of impaired neurodevelopment but who are not offered intervention.

The study consisted of three different subject groups: (1) 30 mothers of preterm infants at risk for development of cerebral palsy (as indicated by an abnormal cranial ultrasound). Half of these infants were randomly assigned to receive standard community care and the other half received early physiotherapy intervention; (2) 35 mothers of healthy preterm infants; and (3) 31 mothers of healthy term infants. Psychosocial assessment of the mothers included a self reported malaise inventory, a semi-structured interview, and when the mother had a partner, the Dyadic Adjustment Scale (DAS). The malaise inventory suggested the presence/degree of emotional disturbance of the mothers. The interview was used to gather information on 12 established adversities, some examples include - deprived inner city location, unemployed head of household, four or more children living in the home, and problems with the mother's family of origin. Depression was diagnosed based on the collected information using the DSM-III. The infants were assessed via systematic observation of visual and motor behaviors and administration of the Bayley Scales of Infant Development. Assessments took place three times during their first year (i.e., at age 6 weeks, 6 months, and 12 months).

Resource Article (continued)

Overall results indicated that rates of depression in the mothers of preterm infants remained stable over the first year of life at roughly 27% and was similar to the rates of depression among the mothers of the full term infants, which was 26%. This finding conflicted with the original hypotheses investigated. The prediction of a disability (based on the ultrasound) did not correlate with mothers becoming more depressed than mothers of healthy preterm and healthy term infants. There was no significant difference between the mothers of infants with disability at age 12 months and the healthy preterm and healthy term infants at the same age. Of the psychosocial adversities, the mothers of infants aged 6 weeks had higher rates of depression when they experienced problems with housing. Several adversities played a larger role in depression of mothers at age 6 months (e.g., unemployment, problems with the mother's family of origin, isolation of the mother, feelings of loneliness, lack of a confidante, and problems with housing). Interestingly, a poor partner relationship for the mother did not become significant until the children were 12 months. Because the rates of depression amongst the mothers were relatively steady across all groups, the child's disability combined with adversity did not indicate any significant interaction. Depression rates for mothers participating in early physiotherapy, decreased over time (i.e., at 6 weeks 44% of depression, at 6 months 38%, and at 12 months 31% respectively) but were generally higher compared to the rate of depression among mothers with standard community care (i.e., at 21% across the three time points).

Interestingly, the predication of a disability and the presence of a disability did not significantly correlate with an increased likelihood of the mothers experiencing depression in this study. Experiencing psychosocial adversity did, however, correlate highly with rates of depression for mothers throughout the study. These results underscore the importance of considering the challenges early intervention families face, both developmentally and psychosocially.

Lambrenos, A. M., Weindling, R., Calam, R., & Cox, A.D. (1996). The effect of a child's disability on mother's mental health. *Archives of Diseases in Childhood, 74*, 115-120.

On the WWW

This months web resource is Parenting Moments by the Infant Mental Health Promotion (IMHP). IMHP has recently developed a growing compilation of parent resources for addressing issues common to parenting young children. Each week a new topic post is added, so you'll want to check this out periodically. To date the weekly topics have included: mental health and brain development, understanding aggressive behaviors, coping with disaster, building social relationships, brain building activities, and how nature affects child development. Each topic is addressed in a parent friendly information sheet and includes tips for comforting, playing, and teaching young children.

http://www.imhpromotion.ca/ParentResources/CPTParentingMoments.aspx

What do the data say?

Can fathers get postpartum depression?

The answer is yes; fathers can have postpartum depression. In simple terms, postpartum depression is moderate to severe depression that follows the birth of a child. By definition it is not exclusive to women, although mothers are at higher risk. Paulson and Bazemore (2010) reported paternal depression at a rate of 10% with relatively higher rates during the three to six month postpartum period. Interestingly, the researchers also found that fathers in the United States experienced postpartum depression at nearly twice the rate of fathers from other countries. The incidence rate of postpartum depression in mothers was estimated at 24% with similar spikes between three and six months after the baby is born.

Individuals with depression, anxiety and a history of mental health difficulties are also more likely to have difficulties after the baby is born. Other contributing factors include having a lack of social support, experiencing high stress levels, having a colicky baby, and having a spouse with depression. When both parents are depressed the baby is at an even greater risk of experiencing lasting negative effects.

While it is not uncommon for new parents to feel anxious and fatigued, have changes in appetite and sleep, and experience challenges with raising a newborn, it is important for parents (mothers and fathers) to be attuned to signs of depression beyond typical parenting. These include detaching from the baby, feeling hopeless, having thoughts of death, feeling overly irritable, and withdrawing from parenting and interactions with others.

Fathers with postpartum depression have also been reported to be short tempered, grouchy, generally difficult to please, and spend less time at home or when home they are not interactive with the baby or other family members.

In spite of the growing awareness of postpartum depression in fathers it can be challenging to diagnose. This is in part because it is not actively screened for and because new fathers have traditionally been less likely than new mothers to bring the baby in for well baby checkups. Increased understanding and awareness of paternal postpartum depression is critical for it to be identified and optimally treated for the benefit of the child and the parents (mother and father).

Paulson, J. F. & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression. The Journal of American Medical Association, 303(19). Accessed from: http://jama.jamanetwork.com/article.aspx?articleid=185905

KIT Newsletters are available online at www.edis.army.mil

Consultation Corner

From May through September 2013, we are excited to have Erin Troup, LCC, NCC, CT as our consultation corner expert. Erin will address the topic *Understanding Depression*.

What are the effects of parental depression on a child?

Research examining the effects of parental depression on the growing brain and overall development of a young child has bolstered understanding and awareness. The Center for the Developing Child at Harvard and Substance Abuse and Mental Health Services Administration (SAMHSA) has identified parental depression as a leading cause of toxic stress in young children. Toxic stress is a type of stress that activates the stress response system for a long period of time, thus altering the way our bodies react to stress in the future. This research is fascinating but also a sobering reminder of how much of an effect a parent's mood has on their child. When we think of a caregiver who is depressed we often have a visual of a caregiver who stays in bed most of the day, "zones out", overeats or forgets to eat and cries often. These are all common symptoms of depression but there are also different types of depression. Caregivers may have an agitated depression where they spend a lot of time being frustrated or feeling anxious. They may also become a bit obsessive compulsive about things and find it very hard to change routine or do something different in their day. With depression it is easy to see that there may be interference in carrying out daily parenting functions. A parent experiencing depression may have a lack of energy and may be at risk for self-medicating through drugs or alcohol to cope with their symptoms of depression.

Babies are born wired to attach and bond with their caregiver. They turn to their mother's voice, they can distinguish their mother's breast milk from other women's breast milk and many of the newborn reflexes are present to create proximity and bonding. As attachment is nurtured and we create a "working model" or a way of understanding how the world works from our primary caregiver. When a baby cries, he is attended to and gets food. A baby learns that he has a voice to alert his caregiver and that his caregiver will attend to him and meet his needs. Imagine what a caregiver, who is depressed and cannot get out of bed to feed a crying infant, may be inadvertently telling the baby about the world. Babies who do not have their cries answered will stop crying because it is no longer a useful skill for them. When we look at babies who have experienced depression in their caregiver we often see them lagging behind in some developmental milestones, particularly those around speech, cognitive and social- emotional functioning. Children may also be affected in their diets (e.g., unhealthy food intake, or malnourishment). A child's sense of self worth might also be lacking compared to other children their age.

Caregiver depression has negative effects on caregivers and children individually but it also has a huge effect on the relationship between parent and child. There is a visible difference in the attachment or bond between caregiver and child. Both the parent and child often display difficulty in coping skills and confusion around giving and receiving comfort or love. Both caregiver and child may also be limited or excessive in their emotions with each other (e.g., very fearful of situations or not attentive

Consultation Corner (continued)

enough in potentially dangerous situations). Children living in a home with a lot of anxiety or unpredictability may look over stimulated or hyper. They tend to move rapidly between play activities that are not necessarily purposeful. They are also unaware of their bodies and they may bump into things or appear clumsy.

In the early intervention system, a parent's depression might also be a barrier for service delivery. Multiple cancellations may occur on the part of the family, follow through with planned activities can be limited, and progress in the child's development may be slowed.

What is the silver lining in all of this? The great news about depression is that it is treatable and there are a variety of options for those seeking support. Talk therapy, medication management, support groups and online support communities can all be effective in working through depression. Doctor's offices and hospitals are getting better about asking about depression and getting individuals set up with support. When children begin to feel like their environment is predictable and nurturing, the behavioral symptoms such as hyperactivity and clumsiness may also begin to subside. As an early intervention provider, your support and resources are helpful for families who may be struggling. Your work with the family and child can also serve as a buffer against the delays that can occur if depression continues.

Continuing Education for KIT Readers

The Comprehensive System of Personnel Development (CSPD) is offering a continuing education opportunity for KIT readers.

In line with the focus on *Understanding Depression*, readers are invited to receive continuing education contact hours for reading the monthly KIT publications (May through September 2013) and completing a multiple-choice exam about the content covered in these KITs.

KIT readers will receive the exam in October 2013. There is no need to register for the CEUs. Rather, if you are interested complete the exam online at www.edis.army.mil Upon successful completion of the exam, you will receive a certificate of non-discipline specific continuing education contact hours.

Thank you for your continued interest in the KIT.
Please share your KIT questions/ideas via email to
EDISCSPD@amedd.army.mil