THE IMPACT OF PERINATAL DEPRESSION ON CHILD DEVELOPMENT

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ABSTRACT

In order to grow, we must accept loss and relinquishment. These psychic movements are frequently constructive and leading to maturity, but they can also be a potential source of disorganizing anguish and they can induce symptoms such as anxiety, fears, somatizations and various difficulties. The arrival of a child, from its very conception to the first months of life, is considered to be a phase of psycho-emotional development that corresponds to a new psychic structure in the mother/father. During pregnancy, the psychic functioning undergoes important modifications that impact the woman’s very identity. During this whole period psychological changes are taking place that manifest themselves by an intensification of signs of pre-existent conflicts and of behaviors, attitudes or desires specific to very early periods of development. The parenting process is all about giving up on being the daughter or the son of one’s parents, in other words about “loosing” one’s infantile position, needs and desires and assuming a new identity, that of being oneself the parent of one’s child. This process allows us to understand the central point of the depressive problem, not only in the course of its development, but also in the context of this “clinic of parenthood.”

Keywords: administration depressivity, depression, baby exposed to maternal depression

POSTNATAL BLUES

It is such a common reaction in the post-partum period that it can be considered normal. It is a disorder that touches most women after birth (especially the primiparae), with peak in intensity between the 3rd and 5th day and with a spontaneous remission after 10-12 days. This minor depressive condition is characterized by feelings of sadness or euphoria, nostalgia, irritability, a feeling of emptiness, of abandonment, of depersonalization, and often somatic symptoms (fatigue, headaches), loss of appetite and sleep disorders. These manifestations go into remission spontaneously after a few days if the environment is soothing and accommodating. In psychopathology, D. W. Winnicott (1958) has allowed clinicians to make sense of this syndrome that he calls "primary maternal preoccupation" and which he qualifies as "a normal illness" [1].

Structuring and useful, this state allows the young mother in the last moments of pregnancy and in the baby's first moments of life, to put herself aside and dedicate entirely to a very fine intuitive understanding of messages cooed by her baby. According to Winnicott, this state will lead the mother, thanks to this hypersensitivity to the needs expressed by the baby, to identify with the baby and thus serve as a substitute for the baby's not yet structured psychic. "Thinking for the baby", the mother will serve as an "auxiliary self". Also, when Winnicott says that "a baby alone does not exist", he emphasizes the importance of early interactions for the psychomotor development of the baby [1].

When this blues reaction is severe and persists, it may be the precursor of a true post-partum depression [2].

POSTNATAL DEPRESSION

The PPD clinical manifestations have attracted for many years all the attention of professionals in the field of perinatality and have founded perinatal psychiatry. Epidemiological, biological, sociological, psychological studies on
maternal depression have demonstrated and described the complexity of this syndrome and its consequences. Recamier (1961) is among the first clinicians who has studied disorders in the post-partum period and differentiated melancholy of post-partum psychosis. In 1968, B. Pitt described "an atypical depression in the post-partum period" non delusional, non psychotic. He suggested the concept of post-partum depression and since then, research on the effects of post-partum depression on cognitive and emotional development of the baby have multiplied considerably.

Post-partum depression indicates the entirety of a moderate but chronic psychological discomfort that overwhelms some mothers: sadness, lack of pleasure to live and anxiety can sometimes lead to a genuine mental pathology - both for the mother, but more seriously, also for the baby. It is a pathology that should not be neglected nor by the family, nor by medical personnel. It is a pathology that reaches at least 10% of parturients, and more. Women do not dare to confess, claiming fatigue and taking care of the child, and in the case of primiparal the identification of this state is more difficult as their body in itself is the stage of so many transformations.

CLINICAL BENCHMARKS:

Withdrawal of the mother, who isolates herself; she seems daunted, putting the child at a distance, indifference or often irritability when the child wants to be fed again;

A state of anxious arousal in a woman who seeks to be a "good mother, an ideal mother" in a displacement of her inner feelings. She feels she is a bad mother or she feels judged and every difficulty she encounters with the child fuels this kind of thinking. She becomes irritable, anguished and tense, which can disrupt the couple and stress the difficulties. She cannot sleep, she is tired and the fatigue accumulates leading to exhaustion. An aggressive woman can be a depressed woman.

Sleep disorders are early signs of all decompensation in post-partum period, particularly insomnia, in other words the impossibility of the woman to allow herself to fall asleep when the baby sleeps or when someone else takes care of him. Maternal anxiety can also express the concerns she has for her baby or related to his health, which will make her turn repeatedly to the pediatrician, the family doctor or to the emergency services.

Disorders of the baby, a baby who is not sleeping, crying a lot and having interaction disorders should alert us and make us think about a possible PND. All these disorders of the baby can rapidly increase the sense of maternal incompetence and intensify the depressive feelings. Some depressed women provide physical care of the child in a mechanical, operative manner, putting their affects at a distance. The diagnosis is not easy because the child is well groomed, well dressed and gaining weight, which can easily be calming for those around her.

Post-partum depression is a torpid disorder, which can last for months without spontaneous improvement and, in the absence of treatment, it risks painfully compromising the quality of the relationship and interactions with the child in the first year of his life. Treatment is more difficult as the close ones refuse to recognize this pathological condition. Nevertheless, the negative effects which always arise make this treatment a true emergency.

RISK FACTORS

The existence of a psychological vulnerability - women with low self-esteem, women who have already suffered a psychological disorder, depression, PPD, anxiety disorder - have a higher risk than other women to develop PPD;

Family history - if a family member has suffered from depression or PPD, there may be an increased risk for their offspring;

A relationship between pre-partum and post-partum mental disorders is known - women who have suffered from a depressive or an anxiety disorder during pregnancy are more likely to develop PPD. More than half of women who have suffered from depression during pregnancy will suffer from a post-natal depression [3]; Stressful life events - these are factors that predispose to depression, especially if they occur in the perinatal period, the loss of a parent is a major risk factor;

The quality of marital relationships;

Lack of a supportive partner, family and close ones favors the risk of depression;

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The quality of relationship the mother has with her own mother plays a crucial preventive role. Epidemiological studies have highlighted that the lack of warmth, attention, care, support and parental indifference predispose to PPD;

- Relationship between sexual abuse and childhood maltreatment;
- An early separation of the mother from the infant may increase the risk of PPD through the impact it has on early attachment;
- Child characteristics (restlessness, difficult temperament, crying frequently) seem to favor the risk of PPD;
- A teenage mother;
- Nationality and origin;
- Numerous prior pregnancies;
- Abortions;
- Obstetric complications;
- Sex and health of the baby;
- Breastfeeding.

In conclusion, there is no single causal factor at the root of PPD but there are many intra-psychic, physiological, environmental elements whose presence may predispose to developing PPD, but their existence is not enough to trigger a depression.

Risk factors more specifically related to the process of parenting were highlighted by psychotherapists who have studied the parent-baby relationship [4,5].
- Also called adaptive factors, related to the intensity of the psychic effort required for the mutual adjustment of the mother and the baby;
- Maternal phantasmal world related factors and the representations the mother has of the baby or representations that feed her projections on the infant: she can think about him that is good or bad, moody, fragile or strong, healthy, weak, etc.

Starting from the seventh month of pregnancy, the mother has already a mental representation of the child who will come Ammaniti [6] which allows her to assign to the baby, even before meeting it, desires, qualities or faults, expectations and fears.

Psychotherapeutic interventions that relieve the baby from these projective motions are very effective and have a soothing effect not only on the functional disorders of the baby, but also on the maternal mental state.

PPD IMPACT ON CHILD

At birth, the baby is not yet a mature and autonomous being, he needs to be taken care of and have interactions with adults in order to develop and establish a sense of identity. Even from the first moments of his life, regular dual contact with someone “other” is crucial for his development.

Starting from repeating gestures, touches, sounds, facial and body expressions, the mother communicates various signals to her baby. The latter adapts his behavior according to the messages he receives, so, for example, to the warm voice of the mother he will answer by cooing.

Research on early social development showed a remarkable sensitivity of babies to the quality of interpersonal interactions with the environment since the first days of life. Very early, the baby seeks to imitate facial expressions and movements; he responds in a selective manner to human stimuli more than to non-human stimuli.

As shown by Breazelton and Cramer [7], at the age of two months the baby interacts with the adult in a complex manner with a repertoire of well organized gestures and facial expressions. Interactions are bidirectional.

What happens to the baby in the case of maternal depression during the first weeks of life of the child?

The mother, caught in her sadness and anxiety, does not have the sufficient physical availability to focus on the baby, to put herself in his place, to identify with him and to think for him. She lacks the empathy necessary in order to feel the emotional state of the baby.

The exchanges with the child are either “neutral” and without emotion, or colored by negative emotions. She does not have the strength to offer him something more and cannot take care of him more than in a mechanical, operative manner. The child tries through the ways he has at hand and according to his own characteristics to counteract this lack of stimulation. However, maternal depression does not always affect the relationship with the child. Studies show that the interactions of some depressed mothers resemble those of
mothers without depression, without repercussions on the quality and frequency of exchanges [3].

In 1978 Tronick et al. [8] described the particular reaction of an infant (aged 1-4 months) placed in front of his mother, who has been asked to keep an impassive facial expression and to be unresponsive to the interactive demands of the child. After about 20 seconds during which the child tried to engage his mother as usual, the child's behavior changes: he becomes serious, he is agitated, he gazes or looks away. Facial features, especially the mouth, take a downward position and the face and the head seem to express discouragement. Facial expressions become less frequent, giving the face a "serious" look, and he gradually withdraws completely from the interaction, sucking his fingers, swinging his head, focusing on retreating.

This example is illustrative of the situation when the mother cannot empathize with her child and no one other replaces her in this function. The child himself may become "depressed" by inhibiting his vital force. He becomes, therefore, very little reactive to what surrounds him; he does not manifest pleasure towards different stimulations. In severe cases, he no longer requires food; he can also refuse to eat just like in the cases of severe anorexia in the newborn.

Certain maternal depressions occur more through anxious agitation than by apathy. In these cases, the interactions with children are over-stimulating. As they are not congruent with the spontaneous needs of the baby, they are also pathogenic, just like those that lack stimulation. These children need to develop ways to protect themselves from excess stimulation and the lack of empathy that causes an inadequacy between his needs and what he receives.

Numerous different symptoms can translate the suffering of these children: restlessness, irritability, excessive crying, sleeping disorders, children which are hard to comfort.

**CONSEQUENCES OF PERINATAL DEPRESSION ON THE CHILD**

**On short term:**
- Relational disorders;
- Food and digestive disorder [9];
- Sleep disorders [10];
- Crying and excessive manifestations [9];
- Neglect, abuse;
  
  **On long-term:**
- Less secure attachment;
- Cognitive deficits [11];
- Attention deficit;
- Expressive language disorders [11]
- Behavior disorders;
- Affective disorders;
- Difficulties of adapting to school, etc.

Treatment of postnatal depressions often allows a positive long term evolution of child's difficulties: improvement of mother-child relationship, his behavior, his cognitive and emotional capacities.

The clinical reality shows us that the baby is, unfortunately, often the victim of his mother's depression. But he can also be the one who draws our attention on the difficulties of his mother / parents, by its symptoms and behavioral changesm [12-14].

We believe that the treatment and therapeutic interventions in these situations must be multidisciplinary addressed considering the needs of the mother (monitored by a team of psychiatrists adults, medication) and the child's needs (pediatric and pedopsychiatric dimensions) and the dyad and triad (parent-infant psychotherapies, interactive counseling, support groups).

**REFERENCES**

8. Tronick, E. H. Als, L. Adamson, S. Wise, and T.B. Brazelton: " The infant’s response to entrapment between contradictory messages in face to face conversations...