Annotations

Depression in mothers of young children

During the last five years, depression in mothers, particularly those with children of pre-school age, has become a major topic of discussion among child psychiatrists. At first sight this apparently recent interest appears surprising. The importance of parental depression is mentioned frequently in clinical descriptions of families with disturbed children, and for some time it has been known from systematic studies that any chronic parental illness, physical or psychiatric, can have a deleterious effect on children. The current growth of interest (and concern) arises from the results of a number of research projects carried out during the 1970s. Epidemiological studies, looking at women in the community, show how very common is depression in mothers of children aged under 5, and how widespread its effect can be on family life and on children’s development and health.

Diagnosis of depression

In examining this body of new work it is necessary first to consider what is meant by depression. Interest has begun to move from the severe, but fortunately rare, picture of psychotic depression (in which the risks of infanticide and suicide have always to be considered) to the much more common syndrome of neurotic depression. Paradoxically psychotic depression is, with modern physical methods of treatment, easier to treat than the neurotic disorder. Neurotic disorder is more bound up with the everyday life of the patient. Psychomotor retardation, delusions, and depressive hallucinations are rarely present but symptoms of anxiety are common. The woman will generally feel subjectively sad and miserable, and lacking in energy. There may be frequent bouts of weeping, and difficulty in getting off to sleep. Disturbances of appetite are common. These will often lead to loss of weight but in some cases overeating and weight gain will occur. Disturbances of interpersonal relationships are very common with irritability and ‘snappiness’ expressed towards other family members. Anxiety symptoms are experienced through bodily manifestations—such as palpitations or headaches, transient feelings of panic, and obsessional behaviour.

Prevalence of depression in mothers of young children

An important contribution to the study of depression in women is that of Brown et al. In a randomly selected sample of women living in inner London they found, using standardised interviews, a prevalence rate of 16%. This overall figure disguised very pronounced social class differences with rates of 5% for middle-class and 25% for working-class women. Equally striking differences were found if the women were examined according to their ‘life stage’. Rates were lowest both in young and older women with no children at home. The highest rate was 42% for working-class women who had children under age 6 living at home (for similar middle-class women the figure was only 5%). This was no freak finding, for an identical rate was found for mothers of pre-school children who lived in a different working class area of London. Using similar techniques of evaluation, rates of depression of between 15 and 20% have been found during pregnancy for both middle- and working-class groups of women.

Continuity in depression

The figures quoted above are prevalence rates from cross-sectional studies. Although it was necessary for the depression to have been present for several months in order for it to be rated as a true ‘case’, it is clearly important to know if this is a condition which most mothers will experience for a limited time or whether some of them will experience prolonged depression throughout the early years of motherhood. A continuing longitudinal study suggests that although transient cases do occur there is a large group of women who will remain chronically depressed. In a random sample of primiparous women from a working-class area it was found that of the small group of women who had been depressed before their pregnancies, the majority remained so throughout the first years of motherhood. They were joined by a group of women who had their first experience of handicapping depression after the birth of their first child. Of these one-half remained depressed. In all, 10% of the mothers in this random sample were depressed throughout the first 3½ years of their child’s life.
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Effects on the child

It is possible to detect the effects of maternal depression from the very earliest stage. In a study from Rochester, Zax et al. chose a group of pregnant women with neurotic depression, as one of their control groups in a study designed to examine the effects of maternal schizophrenia. The surprising result was that the worst outcome was found in the group with the apparently less severe psychiatric disorder. The babies born to the depressed women had lower Apgar scores, and there were more fetal deaths in the group, than for the normal controls or the schizophrenic group. The study showed too, that babies born to women who had been depressed during pregnancy, although not of low birthweight per se, were of significantly lower weight than those born to nondepressed women. This finding may well relate to the depressed woman's lesser use of antenatal services and higher rate of smoking (S N Wolkind, in preparation).

In examining postnatal effects the most common association found is with behaviour problems in the child. It would appear that depressed mothers have considerable difficulty in coping with daily problems which arise in child care. In particular, their children are far more likely to be difficult to manage and to have temper tantrums. They may also be delayed in certain developmental milestones and are likely to be later in achieving day and night bladder control. Important as they are, behavioural problems may not be the only effects. Brown and Harris found in their random sample of families that 9% of children under age 15 had had an accident at home during the previous year. For children of depressed mothers the figure was 19%. This finding suggests that there may be a whole area that needs further investigation. We know very little of how maternal depression affects perception of child health or use of medical services. There is surprisingly little known about its role in either physical or psychological child abuse.

Recognition of maternal depression in paediatric practice

All these studies were conducted by nonclinicians who were using standardised interviews of known reliability and validity. They demonstrate that, with instruction, it is not difficult to detect depressive disorders. In most of this work it has been found that only a few of the depressed women had been recognised as such by doctors with a clinical responsibility for the family. Some depressed women regard their condition as the norm and would not think of volunteering information about their mental state. In others, particularly when it is a child who is presented as the patient, the mother might well feel guilty about her role in the disturbance and be worried about being labelled as an 'inadequate mother'. A sudden switch by a paediatrician from asking about the child to conducting a mental state examination of the mother could be threatening. The most acceptable approach and one which, as will be seen below, is fully justified, is to start from the child. After listening to an account of, say, a child's difficulties in eating and sleeping, it is very natural to suggest that this behaviour must have been having pronounced effects on the mother (and her husband). Most parents will then take the opportunity to describe how they themselves have been feeling and if appropriate will then readily respond to systematic questioning covering their own mood, sleep pattern, appetite, daily life, and relationships. Such a procedure is not time-consuming and an idea of whether a parent may be clinically depressed can generally be obtained in a few minutes. Failure to give this opportunity may well lead to some mothers going from one agency to another, presenting each with a variety of child symptoms in a vague hope that someone will pick up their own distress.

Management of maternal depression

Although paediatricians may insist that they cannot play the role of the mother's psychiatrist, in many cases successful treatment of a child's difficulties will only be possible if these are dealt with in a wider family context. Most parents have great confidence in their paediatricians, who will therefore be in an ideal position to get help started. To do this it is necessary to have a model of why so many mothers become and then remain depressed. The most convincing evidence suggests that even if a woman's vulnerability is heightened by past or constitutional factors, the important precipitating factors are current stress and lack of support. If this is so it is not difficult to visualise a process whereby the depression itself becomes a source of further stress. If the mother is unresponsive, her child may become harder to manage, her husband may become critical of her child rearing abilities. These factors feed the depression and a vicious circle becomes established.

Successful management must aim to break this circle. If depression is profound it could be suggested to the woman's general practitioner that a tricyclic antidepressant might help (the use of minor sedatives should be discouraged; there is little evidence that they are of any help in such cases). The major intervention however, should be towards examining the woman's life. Help from health visitors and social
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workers will often be invaluable. Day care of young children may be required. Any concern about the effects of this on young children must be balanced by the effect on a child of remaining alone all day with a depressed mother. In families where problems are, or are becoming, overwhelming, referral to a child psychiatrist may be needed. The number of depressed mothers is so great however, that this is an area where the best use of the child psychiatrist is in liaison work if the paediatric and psychiatric teams can meet regularly to discuss the general handling of such families. Despite all efforts to provide help there will remain some cases where little change is possible. What is essential is that a critical or punitive approach from professionals does not become yet another factor to be added to the stress-depression equation.

References


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