Supporting Perinatal Emotional Health

... Making it Happen

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Enhancing Parent-Infant Relationships; Theory and Practice

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Research
Attachment research over 60 years, the Decade of the Brain (1990-2000) and the Decade of Behaviour (2000-2010) all provide evidence to justify intervention as soon as possible – pregnancy, 0-12 months, 15-48 months, 5-7 years . . . . . . . a.s.a.p.

Intergenerational transmission
vicious cycle - stressed, distressed parents → stressed, distressed children → stressed, distressed parents → the need to intervene early
Harvard commentary, 2010

- healthy child development provides a strong foundation for a vital and productive society
- early experiences lay a foundation for happy as well as unhappy development
- children’s genes and experiences interact to create physiological adaptations or disruptions
- early experiences are biologically embedded in the development of the brain and other organ systems and have lifelong impacts on learning behavior, physical and mental health.
A growing body of scientific evidence shows that early influences – whether positive or negative - are critical to the development of children’s brains and their lifelong health.

The experiences of children (environments – relationships, physical etc; nutrition) interact with their genetic predispositions to create either physiological adaptations (when development is healthy) or disruptions (when it is not).
BMJ, 2010; epigenetics

- Early experiences can actually leave a chemical "signature" on our genes that determines whether and how the genes are turned on or off.
- This shapes how our brains and bodies develop.
- Physiological responses to early experiences affect adult outcomes in educational achievement, economic productivity, physical and mental health.
Social Bonding and Attachment
Coster & Porges, 2010

- neuroendocrine systems involved in social bonding undergo long-lasting modifications as a function of early experience
- genetic differences are not sufficient to explain individual variations in social behaviors
- the amount of social stimulation the infant receives alters the developing nervous system
- déjà vu? deja entendu?
Thinking about thinking

“I wish to use this opportunity for a moment of personal re-thinking on the subject of our work with children. This, of course, includes work with parents, families, guardians of all kinds, schools of various types, social groupings and other environmental facts and factors, and indeed the state of society here today and tomorrow.”

D. W. Winnicott, 1970
Parenting – adversely affected by acute or chronic stress, distress, depression, anxiety

- Capacity
- Competence
- Confidence

- Acquiring skills (personal experience, training)
- Being able and willing to apply them
Parent-child relationships - not just about other people

- Your own parenting style & childhood?
- If early experiences can be so influential, what are we doing about it?
- What prevents people from implementing strategies based on the substantial evidence we have gathered?
- We all know the jargon and politically correct language but do we use it to avoid thinking?
- How do we achieve a secure society?
Depression = a major world-wide health problem;
Management of depression in modern society:

- 1 in 8 receives treatment – often ineffective
- unclear, inadequate diagnosis
- impact of context – culture, poverty, gender
- corollaries of the illness
- stigma and its impact
- poor health literacy
EPA February 2010 – Mood Disorder

- >60 types in WHO collection
- Instruments / scales problematic
- Unclear limits between depression, reactive states e.g. grief, subthreshold conditions, anxiety states, problems of daily living
- Co-morbidity of anx/dep is the usual state?
- Some mania and some depression is ‘pure’
- Whole spectrum in between has co-morbidity
- So?
"can be fully understood only if it is considered within the context of their lives."

Stewart et al, 2006; IJGO 94, 2007

e.g. depression - biological risk factors but also stress 
violence, sexual abuse, neglect, poverty, discrimination, anxiety, low self-esteem, low social status, lack of power in personal, economic, social, professional and political relationships, and poor physical health

All of which are obviously distressing/depressing?
Postnatal Depression and Fathers
Lancet comment on Paulson & Bazemore, JAMA May, 2010

- meta-analysis; self-report
- between first trimester and 1 year postpartum, 10.4% paternal depression (i.e. x2 other men)
- highest in 3-6 months post birth
- higher in US studies than elsewhere
- +ve correlation with maternal depression
- “Screening, prevention and treatment needs to take the whole family into account.”
The Social Determinants of Health

- If the major determinants are social,
  - the remedies will also be social
    (e.g. Marmot, 2005)

  e.g. the relationship between the marginalised
  and the mainstream
    (e.g. Anderson et al, 2007)

who, what determines these relationships?
Critical

- health (personal; services; environment)
- education (motivation; support)
- employment (training; motivation)
- social and material resources
- key issues: inequitable provision and access; social gradient
Rights-based approach
adapted from D. Tarantola

- policies and programs
- structures and services
- community empowerment
- participation without discrimination
- partnership
- training and implementation
- monitoring
- research
- sustainability
- accountability
Millennium Development Goals 2015?

- eradicate extreme poverty & hunger
- achieve universal primary education
- promote gender equality & empower women
- reduce child mortality
- improve maternal health (mortality)
- combat HIV/AIDS, malaria etc
- ensure environmental sustainability
- develop a Global Partnership for Development
Necessary but not sufficient . .

- you cannot improve child health without tackling poverty
- you cannot improve family health where women are denied education and employment
- interdisciplinary collaboration essential
- research provides evidence, informed policy makers set programs
- workers deliver . . . (practice)
Disadvantage: vulnerable parent → vulnerable child

1. parent: past history or currently experiencing depression, anxiety or **any other** mental health problems; dev delay
2. family history of mental health problems
3. the traumatised – loss (including deaths), violence, abuse, neglect, discrimination, ill-health in childhood, subsequently or currently
4. including Aboriginal Peoples, refugees and many migrants
5. poor relationship with (or no) partner (including DV) &/or mother
6. inadequate social support in general
7. poor, jobless, inadequate housing, isolation
8. adverse obstetric history or current complications
9. sick or damaged baby or “wrong gender”
Social change, health and commitment to early intervention

- Bowlby wanted to illuminate the conditions required for healthy personality development
- then parents would know what was best for their children and
- communities would be willing to help them provide that.

- Is it happening and if not, why not?
- We still are unconvinced?
- The need to accept and address the resistance?
“secure attachments help us to survive temporary bouts of negative emotion and re-establish hope, optimism, and equanimity”

“different forms of insecurity interfere with emotion regulation, social adjustment, and mental health”

flexible (secure) coping strategies are preferable to rigid (insecure)

Mikulincer & Shaver, 2007
Attachment Theory

helps us understand:

- behaviour, attitudes and beliefs in significant relationships
- including why parents adopt a particular style of parenting
- and why we relate to patients in the way we do
- and why we relate to other societies in the way we do
Attachment is

- Critical to child development

- A critical factor in problems with (i) emotion-regulation and (ii) relationships: separation anxiety; conduct disorder; juvenile delinquency; substance abuse; dependency; over-independence; domestic violence; Cluster B personality disorders inter alia

- Poorly understood by those who work with and make decisions about children.
caregiving relationship(s) ensure survival of the infant and species

The caregiver(s) are expected to provide a secure base (Mary Ainsworth) from which to explore and learn how to manage the world and to which one can retreat and feel safe from the dangers of the world.

NB. feeling safe is not the same as being safe
Attachment Theory

- Early relationships with caregivers (attachment figures) provide a secure or insecure base for exploring the world.
- Repeated interactions with caregivers are internalized to form an Internal Working Model (IWM) – a template/pattern.
- The IWM is used (ucs) to perceive, interpret and construct plans and relationships.
Relevant caregiver interactive behaviours to provide a secure base:

1. *sensitivity* - ability to perceive signals accurately & respond appropriately
2. *contiguity of response* – appropriate promptness & frequency
3. *physical contact* – appropriate quantity & quality
4. *cooperation* - absence of intrusion, interference or hostility
5. *emotional tone* – warm, positive
Attachment

- Infant (11-18 months) IWM’s can be measured by the Strange Situation Procedure (SSP):
  - **Organised**: Secure = B
  - Insecure = A or C
  - **Disorganised**: Insecure = D (D/A; D/B; D/C)
Attachment Patterns

- Secure - - - B
- Insecure - - A (avoidant), C (resistant - passive or angry), D

Secure attachment in children (and adults) is protective – makes you resilient

Insecure attachment is a current and future risk factor, e.g. for anxiety, depression, maladaptive behaviour, poor choice of partner, inadequate parenting etc.
Insecure D = Disorganised/disoriented:

= the most vulnerable infants and children (abused, neglected, traumatised)

frightened, frightening care →
confused, anxious infant →
dissociative, unempathic, manipulative, controlling child and adult.

NB. the caregiver has also been traumatised.
Adult Attachment Interview - AAI

Categories:

F    secure/autonomous
Ds   dismissing
E    preoccupied
U/d  unresolved/disorganised

[Also CC – cannot classify]
ADULT ATTACHMENT INTERVIEW

- classification by audiotaped interview
- the emphasis is on the discourse process itself
- the production of a **coherent, cooperative, rational life narrative** from an interaction between two speakers
- Grice’s maxims: quality, quantity, relation and manner
AAI

**Items**
Orientation to early family life – who, where
Relationship with parents when very young
Five adjectives to describe relationship with mother in childhood
Episodes (memories, experiences) to illustrate these
Same with father or other attachment figure
Closest to which parental figure - - why
What did respondent do when 'upset' as a child.
Specific incidents when upset emotionally, physically hurt, ill.
AAI Items cont’d

First separation experience
Feeling rejected as a child
Threatening parental behaviour
Abusing/traumatic experiences
Effects of early experiences on adult personality
Why parents behaved the way they did
Losses of loved ones in childhood or later
Changes in relationship with parents
Current relationship with parents
Relationship with own child – separation; wishes for the future; child’s comment.
Secure/autonomous (F)

- coherent, collaborative discourse
- values attachment
- objective re particular relationships and events
- consistent evaluation and descriptions whether experiences were favourable or adverse
- quantity and quality of material appropriate.
Dismissing (Ds)

- not coherent
- does not value attachment-related experiences or relationships
- insists on inability to recall childhood
- normalises or idealises parents but episodes do not support (may actually contradict) the descriptions
- insufficient in quantity.
Preoccupied (E)

- not coherent
- preoccupied by past attachment-related experiences or relationships
- angry, passive or fearful
- long, grammatically inconsistent sentences; vague phrases; psychological jargon
- excessive in quantity
Unresolved/disorganised (U) or (U/d)

[disruption to attentional processes thru arousal of unintegrated fear]

- lapses in monitoring of reasoning or discourse when recounting experiences of loss, abuse or other trauma
- prolonged silences or eulogistic speech
- otherwise fits into categories F, E or Ds
Unresolved / disorganised (U) or (U/d) Attachment

This is the pattern you see in traumatised adults e.g. Ud / E (unresolved and preoccupied, fearful, angry or passive), and this is what they use in relationships, including their parenting.

NB. the secondary pattern may be Ds, or even F – secure/autonomous; it is the degree of lack of resolution that is important.
Attachment and caregiving in the domestic violence context

- Maternal coherence of mind re attachment is linked with pre-school children’s IQ
- Interventions focusing on changing parenting behaviour are not enough
- Clinical interventions for these children should include helping their mothers achieve a coherent life story

Busch & Lieberman, A&HD, 2010
Attachment and caregiving in the substance abuse context

Step 1. foster the capacity for deliberate, explicit conscious consideration of own behaviour, thoughts and feelings (self-mentalization)

Step 2. foster the capacity to mentalize for the child

Step 3. provide developmental information and guidance & suggest behavioral strategies for intervention

Suchman et al, A&HD, 2010
Working with parents: using the AAI clinically

“listening for changes in the voice; for contradictions, lapses, irrelevancies, and breakdowns in meaning; and for the subtle, ongoing disruptions and fluctuations in the structure and organization of discourse. Indeed, these ways of listening for moments when experience cannot be contemplated or mentalized offer the therapist a view of how the patient defends himself or herself against the intrusion of unacceptable feelings or memories into conscious thought.”

Slade 1999
Using the AAI clinically

- helping to set the agenda for clinical work
- base-line and outcome measure for therapy
- establishing the therapeutic alliance
- improving the clinician’s listening skills
- pointing to loss & other trauma, & resolution or not
- identifying defensive processes
- current effects from past relationships
- forensic recommendations
- identifying an “angel in the nursery”
- monitoring progress in reflective functioning
- selection and training of clinicians

Steele & Steele, 2008
Attachment-based interventions

- WWW; PCIT; STEEP; CoS etc
- psychotherapy using AAI
- CBT etc
- i.e. whatever strategy you like provided you recognise the importance of the therapist-patient relationship
Food for thought

- Attachment theory – not only clinical, but also personal, social & political applications
- The perils of not thinking
- The perils of superficial thought and action
- The elephant in the room is . . . .?
- Do we have gender and cultural equity in our society? other societies? any society at all?
Getting worse rather than better?

- Kohut (1980) argued that, in the later part of the 20th century, parental failures began much earlier than previously because parents lacked the time, energy, inclination and cultural support to provide the necessary, attuned, baby-oriented environment.

Karen R. 1994
Problems - 20\textsuperscript{th} century and beyond

Societal changes weigh against secure attachment

- nuclear families and fewer women on hand to help
- life-long nannies, home-help, servants no longer available
- community depleted by industrialisation, mobility, war, poverty, unemployment, violence
- mass trauma in many societies (e.g. World War I, II)
- the demands of capitalism ("growth is essential")

Bowlby

Grove 1988
20th century and beyond

- emphasis on ambition, competition, achieving goals
- faster pace of life
- a different definition of leisure
- emancipation (?) of women
- the risk-averse society ("Free Range Kids")
- human beings are still hunter-gatherers – perhaps we cannot evolve fast enough to keep pace
If, to thrive emotionally and intellectually, a child needs only that someone (or two or several) be consistently available and responsive, why do we think we need to:

- earn more money to pay for a better school and other material items
- exhaust ourselves to ensure organised rather than spontaneous extra-curricular activities
- buy technology to enhance baby’s / child’s IQ
- teach the baby signals to communicate with us
- limit the child’s independence to ensure safety
Clinical aspects

- the risk-averse - insecure - society
- evidence-crazed medicine
- does everything need a manual?
- technology v. human beings
Problem:

Parents have lost confidence in themselves –
we have lost confidence in them -
and in ourselves?
How did this happen?
What needs to be done?
Preventive intervention

- “Pregnancy and the early years of the child’s life offer an opportune time to prevent a host of adverse maternal, child, and family outcomes that are important in their own right, but that also reflect biological, behavioral, and social substrates in the child and family that affect family formation and future life trajectories.” (Olds, 2006)

- Focus on mental health as well as mental illness.
All women are routinely assessed on selected psychological and social variables during pregnancy and the first postpartum year.

By health professionals formally trained to ask the questions, assess the responses, and offer support or initiate appropriate referrals.

Staff involved are offered ongoing support through reflective, clinical supervision and advanced training programs.

Assessment includes the Edinburgh Depression Scale and Domestic Violence screening.
P&P &EI

- train, support and value the staff
- include them actively in planning and research
- regular, frequent, appropriate feedback to all stakeholders
- think developmentally
- think family and community
- recognise and identify strengths, risks and illness
- treat illness, address risks, enhance resiliency
- mobilise a broad range of resources
- connect –

- the resilience of families and communities is linked
- trauma breeds marginalization, abuse of power, and prejudice
- how stressors are handled is influenced by attachment / connectedness in the family and culture of origin
Enhancing individual, family and community resilience

- connectedness is enhanced by: support systems; access to resources; family, community & cultural ties, resilience
- so we must devise ways to mobilise and implement these
- and ensure sustainability
- we must expect and address resistance
Remember . . .

“in emotional life, much as in history, we are only doomed to repeat what has not been remembered, reflected upon, and worked through.” Karen R. 1994