Parental depression: The case for family-centered approaches

Mark Tomlinson, PhD

Department of Psychology
University of Stellenbosch
South Africa
"SEE—THEY'RE ALL SO BUSY THEY DON'T HAVE ANY TIME TO GET DEPRESSED"
Depressive disorder

- Pervasive low mood
  - Loss of interest
- Sleep disturbance
- Appetite disturbance
- Loss of concentration
- Retardation/agitation
- Excessive fatigue
- Guilt/worthlessness
- Suicidal ideation
Depression

• Depression – fourth leading cause of disease burden

• Affects 20% of adults in their lifetime

• Largest cause of non-fatal burden

• Most data from rich countries

• Barriers to care – 40-70% of individuals will never receive any kind of care

• Positively skewed curve
  – Extreme end – clinically significant depressive disorder
  – Other end – good mental health
  – In between – significant proportion of women – not clinically depressed nor good mental health – “distressed” – may be over 50% (Pakistan study – Rahman, Iqbal et al, 2004)
Mental health and the Millennium Development Goals

• MDG’s – almost entirely ignore non-communicable diseases including mental disorders

• Mental health is strongly linked to a number of the goals

  • Eradicate extreme poverty and hunger (MDG 1)
    • Stressful life events, anxiety, depression – more likely to be experienced by poor people
    • Mental disorders impoverish people – increased health costs
    • Less likely to hold down consistent employment
Mental health and the Millennium Development Goals

- Reduce child mortality (MDG 4)
  - Failure to thrive, depression and growth faltering (Asian studies), mixed elsewhere (South Africa and Ethiopia)
  - Depressed mothers more likely to cease breastfeeding
  - Antenatal depression – related to stunting (Pakistan)

- Improve maternal health (MDG 5)
  - Postpartum depression – effect on child
  - Depressed women – less able to care for themselves
  - Link to maternal mortality directly - suicide
Mental health and the Millennium Development Goals

– Women’s right to equality of opportunity and participation (MDG 3)
  • Women twice as likely to suffer from depression than men

AND YET

Mental disorders relatively cheap to treat
Postpartum depression

Rich countries (O'Hara, 1977)

Goa (Patel et al, 2002)

Pakistan (Rahman et al, 2003)

South Africa, Cooper et al, 1999
Mother child interactions

High risk samples

Depressed
Mothers - more remote and intrusive (less sensitive)
Infants - less actively engaged

(Cooper et al, 1999)

Low risk samples

Depressed
Mothers - less sensitive, especially with boys
Infants - not obviously affected

(Murray et al, 1993, 1996)
Child outcome in the context of depression

Infancy
- Insecurely attached (Tomlinson et al, 2005)
- Increased anger, less affective sharing (Stein, 1991)
- Behaviour problems (Murray, 1992)

Early childhood
- Teacher reports of disturbance (Sinclair & Murray, 1998)
- More negative peer play (Murray, 1999)

Adolescence
- Cortisol disturbances (Halligan et al, 2004)
Generational approach

- Compelling evidence of the effects of parental depression on infants and children suggests

- Two generational approach (parent and child) at every level
What about grandparents?
Three generation intervention
Family interventions: Four principles
(Weissbourd, 2000)

1. Child in context
   • “There is no such thing as a baby”
   • There is no such thing as a child without a family, and the family in the larger context of community life

3. Family self sufficiency model
   • Families better able to support themselves when they receive appropriate support
Family interventions: Four principles
(Weissbourd, 2000)

3. Promoting family well being
   • Fostering favourable development and not simply the avoidance of problems

4. Recognizing the importance of the early years
   • Early environment directly affects brain structure
   • Connectivity formed through relationships with other people
Treatment of depression

- Cognitive behaviour therapy for depression – Pakistan (Rahman et al, 2008)
  - Primary health care workers/Lady health workers
  - 4 antenatal visits, 12 postnatal (10 months)
  - No impact on growth
  - Halved the rate of postpartum depression, less episodes of diarrhea, increased immunization

- Multicomponent intervention for postpartum depression – Chile (Rojas et al, 2007)
  - Psychoeducation, treatment adherence groups, pharmacotherapy
  - Midwives and nurses
  - Significant clinical improvement in postpartum depression
Prevention of depression

- Prevention of depression – mixed evidence

- Trial in India, Goa – no impact (Unpublished)

- Meta-analysis that included any psychological / psychosocial intervention - no overall preventive effect for postpartum depression (Dennis & Creedy 2004)

- Comprehensive interventions that support the healthy development of infants and children hold some promise
An alternative approach

– Focus on parenting
  • Impact of depression on infants and children
  • Bi-directional nature of negative interactive patterns and the relationship to depression
  • Interventions designed to improve quality of parenting or marital relationship also lead to improvements in depression (National Research Council and Institute of Medicine, 2009)
  • Also evidence that when depression has been treated that parenting quality does not necessarily improve (National Research Council and Institute of Medicine, 2009)
South Africa
Thula Sana (Hush baby) RCT

- Model – Nurse Home visiting programme of Olds
- Followed a promising pilot intervention
- Community health workers resident in community
- Two antenatal visits; 14 postnatal visits ending at 6 months postnatally
- Primary outcome at six and 12 months postpartum:
  - quality of mother-infant interactions
- Primary outcome at 18 months postpartum:
  - infant attachment security.
- Secondary outcome at six and 12 months postpartum:
  - maternal depression
The training programme

• World Health Organisation/ International Child Development Programme

• Basic Parenting and Counselling Skills training: 14 x 3 hour sessions

• The Newborn Interactive Assessment (NIA): 13 hours - observed 24 demonstrations & practised at least 10 NIAs

• Additional Workshops: breastfeeding, postnatal depression, pregnancy and the birth process, normal childhood illnesses and child abuse.

IMPORTANTLY

Focus on the mother-infant relationship NOT depression
• Expressing love

• Following the child’s lead

• Having a conversation with the child

• Showing appreciation for what the child manages to do

• Focussing the child’s attention on shared experiences with the caregiver

• Make sense of the child’s experiences by describing and naming them
Maternal depression at six months (*British Medical Journal, 2009*)

![Bar chart showing maternal depression levels between intervention and control groups. The intervention group shows a slightly lower depression level compared to the control group.]
Maternal depression at 12 months

![Bar chart showing maternal depression levels at 12 months for Intervention and Control groups. The Intervention group has a lower depression level compared to the Control group.]
Intrusiveness at six months (p=0.004)
Sensitivity at six months (p=0.010)
Intrusiveness at 12 months (p=0.021)
Secure attachment at 18 months (p=0.029)
An effectiveness study of an integrated, community based package for maternal, newborn, child and HIV care in a disadvantaged community in South Africa

- Study site – Umlazi, Durban
- Develop and test an integrated MNCH/PMTCT package
- Cluster randomized unblinded controlled trial
- Manualised intervention - train community workers, linking to existing PMTCT, IMCI and newborn care guidelines
- Visits:
  - Two antenatal visits; visit in the first 24-48 hours; visit at day 3 or 4; visit at 10-14 days; final visit at 7-8 weeks
- Content:
  - Birth preparedness; care behaviours; feeding; maternal mental state; illness detection; hygiene; mother-infant relationship (Brazelton)
- Outcomes
  - Exclusive and appropriate feeding; HIV free infant survival; coverage of care (Co-trimoxazole initiation amongst HIV+ infants at six weeks); key maternal care behaviours (illness detection, cord care, infant warmth); care seeking for illness; and maternal mental state
IMPORTANCE SCORE: *(Circle on below)*

- Not important
- Somewhat important
- Least important

CONFIDENCE SCORE: *(Circle on below)*

- Lots of barriers
- Some barriers
- No barriers

4
The Philani Mentor Mothers Project

• The Philani Mentor Mothers Project (PMMP) is a cluster randomized controlled trial concerned with the development, implementation and independent evaluation of a community based home-visit intervention, designed to reduce illness associated with HIV, TB, alcohol and malnutrition in South African peri-urban settlements.

• Target population: pregnant mothers & infants.
• Intervention period: pregnancy until 6 months post birth.
• Assessment period: pregnancy until 18 months post birth.
Philani Mentor Mother Intervention

• Based on the Philani Child Health and Nutrition Project Outreach Program

• A community based home-visit intervention programme, whereby unemployed mothers from intervention study neighbourhoods are employed and trained as Mentor Mothers (MM) to deliver a series of home-visits to all pregnant and new mothers in their neighbourhoods.
Nature of the Intervention

• Home visits take place from the time each mother is pregnant until her infant is six months old

• Intervention designed to be both supportive and educational in nature.

• Intended to empower pregnant mothers to better protect the health of their families by:
  – accessing available clinic services;
  – implementing preventive behaviours in daily life routines;
  – sustaining preventive behaviours over time.
Key Strengths of the Intervention

• By integrating programs for HIV with TB, alcohol and nutrition, primarily by improving parenting, we are mainstreaming HIV prevention into a broader framework of non-stigmatizing, community level support.

• The study is branded in partnership with an existing outreach program (Philani) which is established in the community primarily as a nutrition program, not an HIV program, thus further contributing to reduced stigmatization of the program.

• Co-morbidity of illnesses related to HIV, TB, malnutrition and alcohol in South Africa is frequent. The home-based delivery strategy addresses the cluster of behaviours necessary to deal with chronic conditions simultaneously, as opposed to individually. This is a significant shift from existing prevention models, which typically address one health behaviour at a time.

• The timing of pregnancy creates unique opportunity for behavior change. Infants disrupt existing daily routines, making new routines easier to implement.
Research Outcomes

22 primary outcomes, across 4 domains:

1. Mother’s self-care (AUDIT-C, maternal depression, anxiety, HIV testing and HIV protective behaviors)

2. Mother’s actions for child (number of well-baby clinic visits, immunizations, bonding, child grant)

3. Child outcomes (birth weight, height z-score, weight z-score, WHO cognitive score, FAS, language, motor, social-emotional, adaptive-behavior)

4. HIV+ MAR outcomes (use of single feeding method, testing child for HIV, maternal TB screening, HIV knowledge).
Some additional thoughts

- Evidence and implementation
- What about men and fathers?
- A cautionary thought
- The way forward
Evidence and the need to implement
Standards of evidence for intervention research
(The Society for Prevention Research)
Adapted by Olds et al (2007)

• Efficacy trials (under ideal conditions) X2

• Effectiveness trials (real world conditions) X2

• Dissemination research studies (under conditions that affect successful replication)
Yes, it's quite a noise - but are we having any impact?
What about fathers and men?
• Men can be engaged – they want to be engaged

WE SIMPLY DO NOT KNOW HOW TO DO IT IN A COMPREHENSIVE AND SCALEABLE WAY

• We need to find a way to harness the intrinsic reward men can receive from interaction with their children
Family and parenting programs
A cautionary note

• Effectiveness of many of the most popular and well disseminated programs has not been demonstrated (Kumpfer & Alvarado, 1998)

• Prevention programs that aggregate high risk youth in youth only groups may produce negative effects (Dishiono & Andrews, 1995)

• Interventions that do not work with the total family may actually weaken the family (Szapocznik, 1996)
The way forward

Three pronged approach:

3. Familial
   - Two and three generational
   - Siblings and extended family
   - Protective effects of non-depressed alternative caregivers even in the context of maternal depression
The way forward

2. Structural
   • Poverty
   • Interpersonal violence/trauma

3. Interactional
   • Parenting
   • Intrusiveness/remoteness
   • Benefits of improved interaction on mood – learned helplessness and demoralization
HOW COME YOU'RE RICH AND I'M POOR?

MUM AND DAD HAVE HIGHLY PAID JOBS WORKING ON THAT VERY PROBLEM.