Predicting the Origins of Post-Partum Depression Through the Use of Mental Representations

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Publication info: Pre- and Peri-natal Psychology Journal 9. 2 (Winter 1994): 127-148.
ProQuest document link

Abstract: None available.

Full Text: Headnote ABSTRACT: Both the incidence and scope of post-partum affective disorders are more pervasive than previously assumed. Several etiological factors have been implicated but none has fully explained the origins of the condition. This paper proposes that post-partum depression may be predicted from the expectant mother's representations of her own caregiver. Deficits in representational ability may prevent the caregiver from envisioning herself as a competent mother capable of forging an adaptive relationship with the infant. Previewing-a developmental process that predicts maturational change -may enhance the mother's ability to represent adaptive interaction. Previewing techniques may be used to overcome the negative representations associated with post-partum depression, enabling the mother to establish a secure attachment relationship with the infant. This discussion highlights the representational deficits that may contribute to post-partum depression and describes how previewing may help to resolve this depression. INTRODUCTION Giving birth is a pivotal event for a woman. The expectation of a new child entering the family tends to spark a joyful response in the pregnant mother and father. However, it has long been acknowledged that a form of melancholia sometimes descends upon the new mother shortly after the birth. In recent decades, the dysphoria that commonly follows birth has come under greater scrutiny. Investigations have disclosed that this condition, generally referred to as post-partum depression, is complex in terms of its definition, pervasiveness, time of onset, and etiology. Clinicians now recognize that a majority of new mothers may experience some form of dysphoric mood before and immediately after the birth. Because studies have applied different criteria and methodologies, however, the incidence of the disorder varies. Identifying three gradations of affective disturbance that occur after birth may help clarify the issue (Brandon, 1982). At one end of this spectrum is puerperal psychosis, a disabling response involving delusions and hallucinations, that is present in an estimated 1 to 2 of every 1000 new mothers (Kendell, Chalmers and Platz, 1987). Of moderate severity is nonpsychotic post-partum depression, a condition that meets DSM-III-R criteria for a major depressive episode (Cutrona, 1982; Kumar and Robson, 1984) and affects an estimated 5 percent (Cutrona, 1983) to 15 percent (Kumar and Robson, 1984) of new mothers. Significantly, DSM-III-R does not distinguish this form of post-partum depression from other nonpsychotic forms of depression. Finally, transient dysphoric mood, or "maternity blues," is reported in 33 percent (Handley, Dunn, Waldon and Baker, 1980) to 70 percent (Harris, 1980) of new mothers and is so common that some researchers have labeled it "normal" (Yalom, Lunde, Moos and Hamburg, 1968; Paykel, Emms, Fletcher and Rassaby, 1980). For the purposes of this discussion the term post-partum depression is used to refer to the moderate form of the illness. Lack of precision has surrounded the time of onset of the condition as well. Despite the label "post-partum depression," several researchers have argued that changes in mood frequently begin during pregnancy and persist after the birth (Buesching, Classer and Frate, 1986). Researchers are also uncertain about the etiology of post-partum depression. Numerous factors have been identified as causing or contributing to the disorder. Specifically, researchers have correlated post-partum depression with psychosocial influences, including lack of social support (O'Hara, 1986; Atkinson and Rickel, 1984); lack of emotional encouragement (Brown, Ni Bhrolchain and Harris, 1975); and, stressful life events (Paykel et al., 1980). Other factors that have been tied to post-partum depression are neuroendocrine changes (Bleuler, 1954); a previous episode of depression in the woman's life (Saks et al., 1985); genetic predisposition (Platz and Kendell, 1988); primiparous status (Paffenbarger, 1982); maternal physical health during the pregnancy and after the birth (Dalton, 1971); and, neonatal physical status (Blumberg, 1980; Cutrona and

Troutman, 1986). Although these investigations offer compelling insights, none provides a comprehensive portrait of the etiology of post-partum depression. More recently, however, researchers have begun to examine maternal representational patterns as one potential source of depression during the pregnancy and post-partum period. In this context, maternal representation is defined as mental fantasies relating to the woman's present life (i.e., her sense of self and contemporaneous interaction), the woman's past (i.e., her memories of her relationship with her own mother) and the woman's future (i.e., her expectations concerning the infant). Individuals rely upon mental representations to establish relationships with others (Nelson and Gruendel, 1981). Moreover, representational patterns are transmitted across generations and are replicated in attachment relationships (Bretherton, 1987; Main, Kaplan and Cassidy, 1985). The ability to represent begins early in life as the infant interacts with the primary caregiver. Bowlby (1969) posits that young infants develop internal representations that preserve in memory preeminent features of their relationship with the caregiver. As memories accumulate, these representations become "internal working models" replete with material relating to the "self and "other" (i.e., the caregiver) in the attachment relationship (Bowlby, 1969, 1973, 1980). Subsequently, these models are used by the infant to interpret and anticipate a partner's behavior, as well as to guide the infant's behavior. According to representational theory, an individual accesses material contained in the internal working models throughout life in order to negotiate interpersonal relationships. Thus, an expectant or new mother will rely on the experiences she internalized during her own childhood to make predictions about and regulate her interactions with her infant. Significantly, mothers whose representations of their own caregiving experiences are negative have been shown to predict and frequently exhibit conflicted relationships with their infants (Saks et al., 1985; Stern, 1991). The theory of mental representations may offer additional insights into the origins of post-partum depression. Specifically, a woman's inability to represent her infant adaptively may derive from her own conflicted caregiving experiences. This representational deficit may make her susceptible to experiencing dysphoria during the pregnancy and/or after the birth, culminating in an inability to forge a relationship with the infant. Under this theory, post-partum depression may drive from three representational impairments. First, the pregnant woman's representations of her own mother may reawaken previously suppressed conflict (Crittenden, 1990; Stern, 1991). Second, the woman may resent her impending status as a mother and feel psychologically ill-equipped to assume this role (Raphael-Leff, 1986). Third, the mother may be unable to formulate coherent representations of the infant. Representational deficits may also prevent the mother from exhibiting intuitive behaviors, manifestations such as visual and vocal cuing that facilitate the infant's adjustment to the external world and to internal developmental changes (Papousek and Papousek, 1987; Trad, 1990). Previewing, a skill that enables the mother to predict and subsequently rehearse upcoming developmental skill with the infant, may be a strategy for helping expectant and new mothers overcome the representational deficits that may contribute to their post-partum depression. The discussion below focuses on how maternal representational patterns may cause post-partum depression. The use of previewing to predict, prevent and treat the condition is then explored. PREDICTING POST-PARTUM DEPRESSION Predicting an episode of post-partum depression first requires articulating a clear definition of the disorder. Defining Post-Partum Depression The symptoms of post-partum depression catalogued in the literature include emotional lability, brief crying episodes, anxiety, mild depression, confusion, insomnia, irritability, and dysphoria (Handley et al., 1980; Kennerley and Gath, 1989; O'Hara, Zekoski, Philippe and Wright, 1990). Also mentioned is the mother's inability to establish a relationship with the infant, manifested by her lack of interest in basic interpersonal tasks such as feeding the infant and responding to the infant's cues. A final area of focus concerns the infant's constitutional disposition. For example, the infant's temperament may influence the mother's post-partum depression (Cutrona and Troutman, 1986). To better understand the etiology of the depressive episodes that affect many women in the pregnancy and post-partum period, then, it may be helpful to explore three features of the condition: the mother's mental representations of her affective state; the mother's behavioral response to the infant; and, the infant's behavioral response to the mother. What

Factors Predict Post-Partum Depression Identifying factors that may predict post-partum depression has intrigued researchers. One theory associates post-partum depression with the dramatic hormonal changes the woman undergoes during the pregnancy and immediately after the birth (Hayworth et al., 1980). This theory has scientific appeal, since the connection between neuroendocrine changes and other forms of depression has been well documented. However, it remains uncertain whether neuroendocrine change alone may be a predictive marker for the condition since virtually every new mother undergoes these changes, but not every new mother experiences depression. Other studies have noted that the mother's physical health may influence her capacity to relate to the infant after the birth (Dalton, 1971). The physical health of the infant has been identified as a factor that may trigger dysphoria as well (Blumberg, 1980). However, neither of these factors has shown reliability in predicting post-partum depression in a majority of cases. Environmental factors have also been identified as contributing to post-partum depression. One popular theory holds that the woman's perception of social support during the pregnancy diminishes the likelihood of an episode of dysphoria after the birth (Cutrona and Troutman, 1990). In contrast, stressful life events - such as a family death, job loss, or economic hardship - may increase the likelihood of later depression (Paykel et al., 1980). A related environmental theory attributes post-partum depression to a lack of social support by the spouse (O'Hara, 1986). Further, the stress caused by a new infant in the household may be interpreted as an "acute social event" which disrupts the parents' patterns of living and increases vulnerability to emotional disturbance (Shareshefsky and Yarrow, 1973). Attributing post-partum depression to an external source gains credibility from reports that adoptive mothers (Melges, 1968) and natural fathers (Bittman and Zalk, 1978) may also experience depression upon the arrival of a new infant in the home. These studies, then, suggest that environmental factors such as stress and social support can cause, mitigate or contribute to dysphoria during the pregnancy and post-partum period. Yet, the psychosocial factors measured tend to be articulated in relatively inexact terms and are often difficult to assess before either the pregnancy or birth. Earlier episodes of maternal depression may also heighten the risk of later post-partum depression (McNeil, 1986). Studies have suggested that depression during the pregnancy significantly increases the likelihood of experiencing depression during the post-partum period. For example, Buesching, Glasser and Frate (1986) found that expectant mothers manifesting high levels of dysphoria during the pregnancy were three times more likely to report a past history of depression and two and one half times more likely of depression especially during pregnancy - predicts post-partum depression. Thus, dysphoria during the pregnancy may actually signify the onset of an affective disorder which continues after the birth. Although attractive in theory and substantiated clinically, this finding still leaves unexplained the origins of the maternal depression that emerges during the perinatal period. Maternal Representational Ability An intriguing finding has surfaced, however, in several studies: women who experience post-partum depression appear to harbor more negative representations of their own mothers than women who do not experience the condition. This negativity becomes apparent during explorations of the woman's representations of her childhood experience and her emotional attitude towards her own mother (Bibring and Valenstein, 1976). Specifically, the woman's negativity towards her own mother seems, in some cases, to predict the onset of depression during both the pregnancy and post-partum period (Saks et al., 1985). If a woman harbors negative representations about her own caregiver, it is likely that she will lack a paradigm for ministering adaptively to her infant. Since her internal working model is devoid of representations of adaptive interaction, such a mother may have difficulty representing herself in the caregiving role and forging an adaptive relationship with the infant (Stern, 1991; Byng-Hall and Stevenson-Hinde, 1991). Consequently, understanding how mental representations evolve especially representations relating to early childhood experience may provide vital insights about the etiology of pregnancy and postpartum depression. Theorists have posited that early in life individuals construct internal working models of the caregiving figure (the "other") and the "self." These models are based on the cumulative interactions that occur between infant and caregiver (Bowlby, 1969, 1980). By relying on internal working models the infant interprets and anticipates the

caregiver's behavior, while simultaneously formulating his or her own behavioral response (Bretherton, 1990; Slough and Greenberg, 1993; Cassidy, 1988). The phrase "internal working model" connotes a dynamic structure that enables the infant to conduct mental experiments or simulations (Bowlby, 1969). Internal working models are posited to contain an abundance of material concerning the relationship between "self and "other." Specifically, if the infant has experienced a supportive parent-child relationship, the working model of the "other" is likely to include images relating to affection and nurturing, while the "self will be perceived as being worthy of support and affection. In contrast, if the infant has experienced a rejecting relationship with the caregiver, then the working model of a rejecting "other" is likely to be complemented by a working model of the "self as being unlovable. Bowlby also suggests that rejecting parents most probably experienced adverse relationships with their own parents during infancy; these patterns of dysfunctional parenting are then transmitted across generations (Bowlby, 1973). Bowlby's notions comport with those of other theorists who emphasize the importance of mental representations. Sullivan (1953), for example, has noted that the infant internalizes "personifications of mother and me," while Sandier and Sandier (1978) refer to "interactions between self and object representations." As the infant becomes more aware of environmental experiences, cognition -the capacity to formulate meaning - and perception - the capacity to generate sensations - come into alignment (Laughlin, McManus and d'Aquili, 1993). Under this theory of consciousness, an infant who lacks coherent internal working models may have difficulty asserting a meaningful sense of consciousness. If internal working models are the subjective artifacts of the bond between caregiver and infant, then the attachment relationship provides external evidence of the dyadic exchange. Ainsworth, Bell, Blehar and Main (1971) determined that infants are either "secure" or "insecure" in their attachment to the parent and that the infant's attachment status may be evaluated at one year of age. Recent studies suggest that children with insecure attachment patterns tend to have caregivers who are unavailable emotionally (Escher-Graub and Grossman, 1983). When such children reach adulthood, they are prone to perpetuate similar attachment difficulties with third parties (Bretherton, 1990). Given the hypothesis that representations of the caregiving experience continue to affect one's emotional status into adult life and strongly influence the attachment patterns the individual exhibits, it becomes imperative to explore the representations harbored by expectant and new mothers. One way of accessing a mother's representations is to have her provide a narrative concerning her own mother. Significantly, representations by mothers of their own caregiving experience have been directly correlated with the type of attachment relationship they share with the infant. For example, mothers who relate coherent narratives of their own mothering experience tend to have securely attached infants. Similarly, mothers who relate incoherent narratives tend to have insecurely attached infants. Thus, the mother's representation of her own attachment relationship tends to be reflected in the attachment bond she establishes with the infant. In effect, then, the content of the mother's representations becomes a predictive marker for her future attachment behavior with her child. The instrument that has confirmed the strong association between an individual's representation of the attachment figure and subsequent attachment behavior with others is the Adult Attachment Interview (Main et al., 1985). During the Interview, parents are requested to divulge their representations of childhood attachment relationships with their own mother and father, to weigh the influence of these childhood attachments on present relationships, and to describe their overall attitude towards attachment relationships. Three classifications are assigned based on this Interview. First, parents who describe childhood attachments with emotional openness and internal consistency are classified as "autonomous/secure" in their relationships. second, parents who describe conflicted interactions that lack balance are classified as having "preoccupied" attachments. Third, parents who have difficulty recalling childhood events or who provide idealized descriptions which are later contradicted are classified as having "dismissing" attachments. Crittenden (1990) has also connected mental representations with external attachment behaviors to arrive at four patterns of maternal interaction. First, adaptive mothers represent relationships with others in a flexible fashion. second, abusing mothers perceive all attachment relationships - such as those with parents, children

and spouses - to be competitive power struggles and resist incorporating new or discrepant information into their internal working models. Neglecting mothers, Crittenden's third group, consider attachment relationships as being empty and ineffective; they too reject new information. Finally, marginally maltreating mothers may recognize that each relationship poses different challenges, but are unable to represent behavioral alternatives and instead respond frantically with a barrage of ineffective strategies. Stern (1991) has presented a related theory of maternal representation, underscoring the influence of the mother's representation of her caregiving experience with her own mother. According to Stern, psychopathology is reflected in the degree to which themes from the past intrude upon the mother's representations, preventing her from establishing an adaptive relationship with the infant. In this regard, Stern presents three models. The first, labeled the "distortion" model, evaluates whether the mother's representations distort objective reality. For instance, a developmentally delayed infant may be viewed by the mother as "normal," while an objectively normal infant may be considered handicapped. Mothers adhering to the "dominant theme" model represent the infant as participating in themes that have caused conflict for the mother throughout her life. These themes are dominant in the sense that they overshadow representations that would otherwise enable the mother to envision the infant in an adaptive fashion. Finally, the "coherence" model evaluates the degree to which the mother represents her own childhood experience in a coherent fashion. Significantly, the more coherent the mother's narrative of her own caregiving experience, the greater the likelihood that she will share a secure attachment relationship with her infant (Main et al., 1985). In a similar fashion, insecure attachment patterns with the infant may be predicted from incoherent maternal narratives. Regardless of the mother's actual attachment history, it is her representation of that history that counts. She will use this representation - whether historically accurate or not - in the formulation of an attachment bond to the infant. Thus, the coherence of the mother's representation serves as a predictive marker for her future attachment behavior with her child. A variety of researchers have examined the expectant mother's representations during the pregnancy. For example, Ammaniti et al. (1992) explored maternal representations in 23 primiparous women during the third trimester. The women were provided with lists of adjectives describing representations of the self and the infant. By the seventh month of pregnancy, the majority of these women expressed identifiable representations of themselves as mothers which correlated with their representations of qualities attributed to the child. For example, if the maternal representations of the self were affectionate and amenable, the corresponding image was of a calm and easygoing child. Similarly, the representation of an active mother was linked to the image of a self-sufficient infant. Ammaniti (1989) and Fava-Viziello (1989) determined that a pregnant woman's representations of the fetus increase in complexity and richness from the fourth to the seventh month; thereafter, however, representational activity pertaining to the infant goes into eclipse until after the birth, as if the mother does not want to be burdened with a representation of the infant that is too specific. Moreover, Ammaniti (1989) cautions that mothers whose representational activity does not abate may have difficulty adjusting to the infant after the birth. This work correlates with the findings of Condon and Dunn (1988), who determined that a lack of congruence between the "fantasy baby" represented during the pregnancy and the "actual baby" could interfere with the mother's ability to bond with the infant after the birth. Stern-Bruschweiler (1988) reinforces the significance of the mother's pregnancy representations by noting that unless the caregiver is capable of formulating an image of the infant, she may later have difficulty encouraging growth in the zone of proximal development (Vygotsky, 1962). Additional investigations have drawn direct connections between the representations of pregnant women and the behaviors manifested by the infants of these women after the birth. Specifically, Ammaniti (1989) correlated maternal pregnancy fantasies with the Adult Attachment Interview and the Strange Situation in infants of one year. Similarly, Fonagy, Steele and Steele (1991) found direct correlations among the Adult Attachment Interview administered during the pregnancy, the same Interview administered one year post-partum, and the Strange Situation administered one year post-partum to infants born to the women in the sample. Several conclusions may be drawn from these studies. First, our internal working models of the "self and "other" contain

representations of the attachment relationship we establish with the mother early in life. In turn, these models become paradigms for forging new relationships. For mothers, internal working models of their relationships with their own caregivers are the experimental replicas they rely upon to represent the infant during the pregnancy and later to fashion a relationship with the infant. second, psychopathologic responses may become incorporated into the internal working model, causing a distorted representation which may be manifested through maladaptive behavior. Third, negative representations of childhood experiences may act as one etiology for maternal depression during the pregnancy and post-partum period. Under Crittenden's scheme, for example, abusing, neglecting, marginally maltreating and adaptive mothers each harbor different representations of their own caregiving experience and of their relationships with others. These representations influence the mother's perceptions of herself as a caregiver. For example, perceptions of incompetence may cause the mother to experience depression, enhancing the likelihood that she will fail to establish an adaptive relationship with the infant. In turn, the infant may then fail to respond to the caregiver, further intensifying feelings of helplessness and depression. It is posited here that negative representations of the early caregiving experience - and especially the relationship with the caregiver - is one important factor that may cause or contribute to an episode of depression during the pregnancy and post-partum period. Given this hypothesis, are methods available for early diagnosis and treatment of the condition? One method may be offered by a new technique known as "previewing," an interpersonal process that takes place between an adaptive caregiver and her infant during the early weeks and months of life (Trad, 1990). In general, previewing refers to the process by which the caregiver gradually introduces the infant to imminent developmental skill, as well as to the implications such skill will have for the dyadic relationship (Trad, 1992). The previewing process consists of three components. First, the caregiver represents a developmental skill the infant will soon exhibit. For example, the caregiver might notice kicking gestures or grasping motions in the infant. From these cues, suggesting the advent of a new skill, the caregiver might hypothesize that the infant will soon be crawling or grasping and actually envision the infant engaged in this task. Initially, then, the caregiver assesses the infant's developmental status in order to formulate a representation of a new maturational skill. Rehearsal exercises are the second component of previewing. The caregiver converts her representations of upcoming skill into exercises during which she engages the infant in the simulation of a particular skill. As some specific examples, the caregiver might manipulate the infant's limbs to simulate crawling or replicate grasping motions so that the infant experiences the sensation of holding an object. The final component of previewing is the caregiver's sensitivity which enables her to intuitively discern when a previewing episode should be initiated, as well as when the infant is tired and wishes to return to a previous level of development. PREVIEWING AS A PREDICTOR OF PREGNANCY AND POST-PARTUM DEPRESSION As noted, several studies have found that women with post-partum depression often harbor negative representations of their own mothers. When this negativity is present, the likelihood of post-partum depression is enhanced (Saks, et al., 1985). Moreover, studies have also suggested that negative representations of the mother's own mother may be revived during the pregnancy and may act as a prelude either alone or in conjunction with other factors to an episode of post-partum depression (Bibring and Valenstein, 1976; O'Hara, 1986; Buesching et al., 1986). As a result, if a link may be established between the expectant mother's negativity towards her own mother and caregiving experience- evidenced in representational patterns - and her future relationship with the infant, it may be possible to predict early in the pregnancy which women may experience depression later in the pregnancy and during the post-partum period. In this regard, three representations should be explored. First, how does the expectant mother represent her relationship with her own caregiver? second, how does the expectant mother represent herself fulfilling the role of caregiver? Third, how does the expectant mother represent the infant and the relationship she will share with the infant after the birth? By exploring the pregnant woman's representations in these areas, it is posited that the clinician will be able to predict some of the women who will be susceptible to an episode of depression. Pregnancy is a time of introspection. The dramatic physical changes (e.g., body

shape), psychological changes (e.g., acclimation to maternal status), and social changes (e.g., adjustment to marital relationship) triggered by the pregnancy cause the woman to examine her life situation (O'Hara et al., 1990; Cutrona and Troutman, 1986). It is therefore not unusual to expect the woman to reflect upon her relationship with her own mother as a predictor of how she will function after the birth. The early pregnancy period is an especially important time during which to explore the mother's representations of her own mother, since researchers have suggested that the disequilibrium caused by the pregnancy may unleash repressed memories of childhood experience (O'Hara, 1986; Paffenbarger, 1982). In addition, pregnancy may disrupt the mother's customary patterns of living and require her to implement new behaviors (Atkinson and Rickel, 1984). The second type of representation that should be explored during the pregnancy concerns the pregnant woman's representation of how she will fulfill the caregiving role. This representation is especially pertinent since some women will be unable to remember their relationship with their own caregiver or may provide an idealized description suggestive of a dismissing attachment. By investigating the mother's expectations concerning her own caregiving skills, however, the clinician may formulate some predictions about how the woman will be likely to function after the birth. Insights concerning the expectant mother's capacity to represent herself as a mother have been provided by Raphael-Leff (1986). According to this researcher, expectant and new mothers behave as either "facilitators" or "regulators" towards their infants. The facilitator mother adapts to her infant; the regulator mother expects the infant to adapt to her. According to Raphael-Leff, clinicians may use the pregnancy to predict the nature of the mother-infant relationship after the birth. For example, during the pregnancy, fetal movements will evoke unconscious fantasies of conflict within the woman. The facilitator mother approaches the pregnancy as the culmination of a wish to have a baby. She revives archaic childhood images and experiences a sense of enrichment (Kestenberg, 1976). Thus, pregnancy is viewed as a creative act and the woman depicts herself as a generator of life. In contrast, the regulator resists the emotional upheaval associated with pregnancy. She strives to preserve her own identity and represents the unborn infant as a stranger. For the regulator, pregnancy is a tedious process. As suggested by these profiles, the facilitator will be more apt to adjust adaptively to the transformations of pregnancy, while the regulator may resist these changes and therefore may be prone to experiencing depression. Inquiries of expectant mothers help determine how the woman predicts her life will change after the child is born. A key factor to assess in the woman's narrative is the degree to which she harbors positive or negative representations about her upcoming role. In some cases, requesting the expectant mother to predict her future status will cause confusion or the comment that she cannot generate any represervations. This response suggests that the woman is experiencing a representational deficit. That is, the expectant mother's inability to envision how she will function in the future as a caregiver suggests that she may be conflicted about this role (Trad, 1992). To diagnose if conflict is indeed present, the clinician should ask further probing questions designed to stimulate the woman's representational abilities. Questions in this area might include: How do you think you will feel once you are a mother? Can you imagine what a typical day in your life will be like after the infant has been born? If these efforts are of little avail, then the likelihood of an episode of depression later during the pregnancy or post-partum period is enhanced. A third area that should be explored concerns the expectant mother's representations of her infant. The clinician is apt to detect a wealth of material in this area since pregnant women generate prolific fantasies relating to the upcoming birth. Caplan (1959), for example, analyzed the fantasies of expectant mothers and correlated types of fantasies with corresponding trimesters of the woman's pregnancy. In Caplan's scheme, the first phase of fantasy activity spans the time from conception until the mother perceives of the infant's movements in utero (approximately the first trimester). As the second trimester approaches, the prospective caregiver acquires a more realistic perception of the unborn infant as an independent being. At this time, fantasies may be unusual and even slightly odd: the infant may be represented as a dirty object or as a parasitic creature gnawing from within that the mother must expel; alternately, expectant mothers may experience the fetus as a devouring or attacking creature (Pines, 1972a, b; Raphael-Leff, 1980). Finally, according to Caplan, the final trimester is

typified by mood swings that range from pleasure at the birth to anxiety that the fetus might the during childbirth or be born damaged or deformed. The fantasies and dreams of pregnant women may be extraordinarily elaborate, as if they are searching for omens to assuage their anxieties and predict how the relationship with the infant will unfold (Coleman, 1974). These prenatal fantasies have been shown to have some validity in predicting the postnatal relationship between mother and infant. For example, a highly idealized prenatal fantasy of the infant may cause parental disappointment if the infant actually born deviates too much from the expectant mother's representation of the fantasy baby (Condon and Dunn, 1988). Parents whose "reality baby" is a close match to the "fantasy baby" are more likely to be content with the infant after the birth. As Condon and Dunn (1988) explain, during the pregnancy most expectant mothers evolve a representation of a "fantasy baby." This "fantasy baby" evokes feelings of affection, is assigned a specific gender, and has a particular disposition and appearance. After the birth, however, the "fantasy baby" will need to be reconciled with the "reality baby" who has actually been born. As Condon and Dunn have determined, mothers whose first impression of the newborn is negative because the "reality baby" deviates too much from the "fantasy baby" are more apt to experience post-partum depression and have difficulty establishing an adaptive attachment relationship. If this form of negative representation is directed at the infant, it is possible that the infant will seek to eradicate from consciousness the negative experience of interaction with the caregiver (Laughlin et al., 1993). Evidence of the expectant mother's representations of the infant may be assessed by asking her to preview the relationship with the infant. Can she imagine the type of relationship she will have with the infant and how new developmental skills will affect their interaction? Can the expectant mother speculate about the infant's personality? Expectant mothers unable to formulate coherent representations of the infant may be at greater risk of experiencing depression later during the pregnancy or post-partum period. In sum, the inability to represent is hypothesized to indicate psychological conflict. For expectant mothers, three representational areas are pertinent: Does the woman harbor a positive representation of her relationship with her own caregiver? Is she able to represent how she will function as a caregiver herself? Can the expectant mother represent the infant and preview their future relationship? Deficits in any of these areas may enhance the likelihood of an episode of post-partum depression. TREATING POST-PARTUM DEPRESSION USING PREVIEWING Just as previewing techniques may help predict the likelihood of pregnancy or post-partum depression, so too may these techniques offer one method of treating the condition. As noted, depression may sometimes be correlated with the woman's representations during the pregnancy: Is she despondent, hopeless about the future and lacking in a positive outlook? Does she harbor negative perceptions of her own mother and her role as an impending caregiver? Does she exhibit the physical signs associated with the condition, such as weepiness and emotional lability? Post-partum dysphoria may also be diagnosed by observing the interaction between caregiver and infant. In this regard, the caregiver's failure to establish meaningful contact with the infant within the first few weeks of life may be considered evidence of post-partum depression. When post-partum depression has been diagnosed, it is recommended that a treatment plan be formulated to improve three areas of function. First, the mother's representations of the infant should be reviewed and enhanced. In this regard, the mother's representations of her own mother may be evaluated and she may be helped to work through any negative representations of her own caregiving experience that may be transferred inadvertently to the infant. second, treatment efforts should strive to bolster the mother's ability to promote an adaptive interaction with the infant. Many mothers already possess the skills necessary for establishing such an interaction, although conflict may mute their capacity for articulating these skills. In other cases, mothers may be less adept at manifesting intuitive behaviors and may need to learn new skills. Third, intervention should extend to an awareness of the infant's developmental status. Although the mother may be the primary focus of attention with regard to treatment, the infant should not be ignored. The infant's display of appropriate developmental skills should be reviewed, as should the infant's overall responsivity to the caregiver. Indeed, infant responsivity may ultimately become a signal of the mother's improved status. Numerous reports have profiled the behavior of infants exposed to caregivers manifesting

post-partum depression. Specifically, such infants tend to lack the responsivity of infants exposed to caregivers whose behavior is adaptive. Moreover, the emotional spectrum of infants of depressed mothers is significantly muted in comparison to the affective portrayals of infants exposed to nondepressed mothers (Field, 1982, 1990). If exposure to a depressed caregiver persists, the infant may begin to withdraw from the environment, as well as to envince physical deterioration of the type that has been described in infants deprived of an adaptive nurturing environment (Spitz and Wolf, 1946). Enhancing Maternal Representations The mother will tend to be less skilled at establishing an adaptive relationship with the infant if she harbors negative representations of her relationship with her own mother. To address these negative representations, the therapist should first encourage the new mother to disclose her memories of her own caregiving experience as best as she is able. A second step involves eliciting from the mother a description of how she thinks her own caregiving experience will influence her interactions with her infant. As a third step, the clinician may assess how these representations are likely to impact on the infant's development. The therapist may next encourage the caregiver to preview future interactions with the infant. For example, the therapist might ask: "Can you predict what it will be like when your baby is able to walk?" For caregivers unable to envision imminent developmental skills, the clinician might focus on discrete interactions taking place in the present by asking: "Can you describe what the baby is doing now?" Many depressed mothers will have difficulty formulating even these specific representations. Therapists may then use additional techniques to assess the mother's representational skills. For instance, the infant may be placed in the mother's direct visual field and the therapist may begin interacting with the infant. If the mother still remains unable to formulate representations, she may be shown videotapes of adaptive mothers interacting with their infants. In effect, the therapist's efforts are directed at encouraging the mother to focus on the infant as a developing individual whose advances in skill may, to a significant degree, be predicted and guided. Enhancing Interactional Patterns Because some pregnant and post-partum depressed mothers may be unable to maintain stable representations of their infants, a helpful strategy is to bring the infant into the mother's presence. Once this is done, the mother may be asked to carefully observe the infant. Subsequently, the mother may be asked to describe the infant's facial expression and the emotional message embodied in the expression, to characterize the infant's gazing patterns and vocal intonations, and to describe the infant's psychomotor responses. This exercise - which should be performed before the caregiver is asked to generate representations about the infant - is designed to reinforce for the mother the infant's objective developmental status. That is, the infant is an independent personality who should not be confused with representations of the caregiver's mother, with the caregiver herself, or with the caregiver as an infant. By encouraging the mother to continually focus on the infant as a unique individual, this independent status may eventually be represented. A second interactional strategy requires the caregiver to represent an imminent developmental skill the infant is likely to exhibit in the near future. To foster these representations, the mother may be asked to focus on the infant's motor skills and emotional cues. By making predictions in these areas, the mother may also acquire greater confidence in her caregiving abilities. Through the techniques of predicting imminent skill and observing the infant, maternal confidence may be reinforced, a step in the direction of overcoming postpartum depression. Enhancing Infant Responsivity A final area to explore in the treatment of post-partum depression involves the infant's status in the dyadic relationship. In many respects, the mother's psychological condition will be reflected through the infant's behaviors. That is, although the mother, as an adult, will be adept at disguising her emotions, the infant's emotions will be manifested overtly. Observing the mother's tendency to respond or fail to respond to the infant, as well as the infant's reciprocal response, provides insight into the mother's condition and into how her behavior influences the infant's developmental capacities. To help the mother resolve post-partum depression, it is posited that the therapist should point out areas of infant responsivity and encourage the mother to respond to these infant signals in an appropriate fashion. By doing so, the tendency for the infant to reciprocate is enhanced. As these strategies are repeated, the mother comes to appreciate that she too is capable of triggering an adaptive response in the infant. This

form of reciprocal exchange may act as a viable means of treating pregnancy and post-partum depression, as well as stimulating a more adaptive interaction between mother and infant. CONCLUSION One approach to determining the etiology of post-partum depression may lie in examining the representations of the expectant and new mother. In particular, pregnancy and post-partum depression appears to be correlated with the negative representations the woman harbors concerning her own caregiving experience. These negative representations -which may function alone or in conjunction with other factors to precipitate depression -may lead the mother to question her competence as an adaptive caregiver, causing her to engage in maladaptive interactions with the infant while simultaneously experiencing a sense of loss and depression. Previewing, a process that encourages the mother to represent her own infancy experience, her role as a caregiver, and the status of the infant more objectively, may help in overcoming these dysfunctional patterns. Subsequently, these representations may be used to predict imminent developmental skills and to establish a more adaptive relationship with the infant. As the attachment with the infant improves, the new mother may gain confidence in her skills and gradually relinquish negative representations of her own caregiving experience. In turn, she will become more skilled at predicting new infant skills. This process may also enable the therapist to clarify the role of negative representations in the etiology of post-partum depression. To date, previewing techniques have shown success in individual cases of mothers with depression during the pregnancy and post-partum periods (Trad, 1993). Therefore, clinical trials applying previewing techniques to groups of mothers manifesting the symptoms of post-partum depression are recommended to assess the full benefits of this method. Such trials could evaluate the viability of previewing for generating positive representations relating the mother's perceptions of the caregiving role and of the infant, as well as enhance mother-infant interactional patterns and increase infant responsivity. The demonstrated success of previewing with these post-partum mothers would suggest that the technique might also be of value for women experiencing dysphoria during the pregnancy.
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Publication title: Pre- and Peri-natal Psychology Journal

Volume: 9

Issue: 2

Pages: 127-148

Number of pages: 22

Publication year: 1994

Publication date: Winter 1994

Year: 1994

Publisher: Association for Pre&Perinatal Psychology and Health

Place of publication: New York

Country of publication: United States

Journal subject: Medical Sciences--Obstetrics And Gynecology, Psychology, Birth Control

ISSN: 08833095

Source type: Scholarly Journals

Language of publication: English

Document type: General Information

ProQuest document ID: 198682702

Document URL: http://search.proquest.com/docview/198682702?accountid=36557

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Last updated: 2010-06-06

Database: ProQuest Public Health

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