Editorial

Mind the gap! Helping the children of mothers with postnatal depression

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Which service should meet the needs of the children of mothers with postnatal depression? The Scottish Intercollegiate Guidelines Network (SIGN) recently published advice on the Mangement of Postnatal Mental Illness (Scottish Intercollegiate Guidelines Network 2002). Contained in the guidelines is the distilled wisdom of many authors, further mulled over and graded on strict methodological grounds by a multidisciplinary team. The product is without doubt sound, applying the highest standards to reach evidence-based conclusions. In summary, from the point of view of the welfare of the mothers, postnatal depression is very little different from depression at any other stage of the life cycle, a common and distressing but treatable condition. The risk factors for postnatal depression, that is, lack of social support, poverty and previous episodes of depression, are no different from those at any other time. The symptom pattern and severity are indistinguishable from other depressions and respond just as well to the treatments of choice, including medication and cognitive-behavioural therapy. The frequency of depression after the birth of a child is no greater than at any other time, and might even be lower than during pregnancy (Fergusson *et al.* 1996; Evans *et al*.2001). The single unique characteristic of postnatal depression is the presence of a child. The main reason for concern is not the mother's mental health, though of course that deserves appropriate treatment, but the possibility of short- and long-term consequences for the infant's cognitive, social and emotional development. Depressed mothers make more negative and fewer positive responses to their babies and the infants learn a style of interaction that transfers to their subsequent interactions with other people (Field *et al*.1988). Longer term adverse influences have been demonstrated on children's language development, IQ and social development with boys probably more vulnerable (Coghill *et al*. 1986; Sharp *et al*. 1995; Murray *et al*. 1996; 1999). The effect seems to be particularly related to the quality of child-focused speech in the first year of life and the effect persists even if remission of the maternal depression occurs after the first year of life (Murray *et al*. 1993).

On the basis of the SIGN guidelines, integrated care pathways (ICPs) are now being devised. However, none that I have seen includes any attempt to pay particular attention to the needs of the infant. Most have taken considerable care to identify postnatal depression. Others have gone further so that identification of the postnatal depression at 6 weeks postpartum initiates special 'listening visits' from the health visitor. If these fail to reduce the Edinburgh Postnatal Depression Scale (EPDS) score by 14 weeks, a referral is triggered to adult mental health services. However, the children of depressed mothers continue to fall through the gaps in services. No ICP to date has indicated what steps might be taken to protect the development of the infant, or who might be made responsible for this work.

Looking at the options for intervention, Cooper *et al.* (2003) confirmed that amelioration of the mother's depression as measured by the EPDS at 4 months was equally well achieved by cognitive-

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behavioural therapy, non-directive counselling or psychodynamic therapy, all of which were more effective than routine primary care. Only psychodynamic therapy made a significant improvement in diagnostic status on a structured diagnostic interview (Spitzer *et al.* 1989). The benefits of treatment for the mothers were unfortunately no longer evident by 9 months post partum. However, from the children's point of view, each of the treatments made only minor differences in early interaction and none of them had any effect on improving the security of mother-child attachment or any child outcome at the age of 5 years (Murray *et al.* 2003). If this experienced team of therapists and researchers could not make an impact on the welfare of the children through the best means at their disposal, then I would suggest that the means tested are not the right ones. There is no support for the assumption that ameliorating the mothers' depression necessarily or automatically repairs the mother-child relationship. Direct work on parenting may be needed to make an impact on crucial aspects of the mother-child interaction.

Lynne Murray's work has already identified some early factors that indicate risk to the child (Murray *et al.* 1993). She identified infant-centred speech in the early weeks of life as a key variable. If mothers engaged their children in infant-centred speech, rather than talking to the infant about their own woes, then even though the mothers might have been depressed, the infants fared well. If infant-centred speech was absent, the children did less well in later language development. It seems inherently unlikely that the content of mothers' speech to a pre-verbal infant could have any measurable effect some years later unless this infant-centred speech was a marker for a mother's ability to tune into her baby despite her own depression. This active enjoyment and involvement with the baby might continue to act across the later months of the child's life, and furnish a route to maintain long-term effects.

Adult mental health services rarely regard the children of their patients as part of their remit. Child psychology and psychiatry services rarely receive referrals of children younger than about three except with suspected major developmental disorders. By this stage the direction of the mother-child interaction has been set, and the child of a depressed mother already has observable deficits. These deficits seem to persist even when the mother's depression remits. Murray *et al.* (2003) also note that although many women were pleased to receive additional support in the post-natal period, a few refused any contact. These may represent a group at particular risk. Those who are distrustful of services may have pervasive difficulties in making relationships, which generalize to difficulties in developing warm and intimate relationships with their babies.

The gap is clear. Which service can respond to the need to develop and evaluate effective interventions?

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