A Case Study of Postpartum Depression & Altered Maternal-Newborn Attachment

ABSTRACT
This article presents a case study of a new mother experiencing postpartum depression and altered attachment with her newborn. Theories related to postpartum depression and maternal-newborn attachment are reviewed, and evidenced-based strategies for care are discussed in the context of the case.

Key Words: Postpartum depression; Maternal-newborn attachment; Case study; Nursing.
Postpartum Depression

Postpartum depression is a leading complication in childbirth (Gaynes et al., 2005). An evidence report commissioned by the Agency for Healthcare Research and Quality (AHRQ) found that as many as 19.2% of new mothers can experience major or minor depression in the first 3 months postpartum (Gaynes et al., 2005). However, it is estimated that only 20% of women with postpartum depression are diagnosed and treated, leaving thousands to suffer in silence. 

The experience of postpartum depression has been shown to lead to a disruption in the maternal-newborn bonding experience, the first connection a mother makes with her newborn (Beck, 2002; Beck & Driscoll, 2006; Karl, Beal, O’Hare & Rissmiller, 2006; Klaus & Kennell, 1976). If bonding is disturbed, then maternal-infant attachment can be interrupted. Attachment is more complex than bonding and includes an emotional component that requires time to process (Karl et al., 2006). Altered attachment also can have an unfavorable influence on the child’s growth and development. Some studies have suggested that children with altered attachment may eventually demonstrate emotional and cognitive deficits (Armstrong, Fraser, Dadds, & Morris, 2000; Essex, Klein, Miech, & Smider, 2001).

Case History

“Stephanie” was a 29-year-old primiparous mother of a baby girl named Emma. She came to me for care when Emma was 6 weeks old and presented with moderate to severe depressive symptoms, which had been ongoing for 2 weeks. Her symptoms included sleep disturbance, loss of appetite, and panic attacks. In addition to these symptoms, Stephanie complained about not having “normal” feelings toward Emma. She felt as though the baby was not hers and that she was a total stranger. Stephanie told me that she did not retain any of the prior good feelings she had while she was pregnant and felt that although she had bonded with the newborn in utero, those feelings were now gone.

Attachment Theory

Attachment theory is the psychological propensity for closeness to another, particularly one specific person. A person who is experiencing attachment feels secure when this someone is in attendance and may have increased anxiety when he or she is not. Bowlby (1988) stated that “Affectionate and responsible parents throughout infancy, childhood and adolescence provide a boy or girl with a secure base from which to explore their world and to which to return when in difficulty... [attachment makes it] more than likely that a child will grow up to be a cheerful, socially cooperative, and effective citizen and to be unlikely to break down in adversity” (p. 9). According to Herring and Kaslow (2002), the emotional bonds formed with families are essential to how children mature psychologically and developmentally and suggest that a child requires dependable and reliable bonding with his or her primary caregiver.

According to Mercer’s (1995) seminal work, maternal attachment begins during pregnancy and continues beyond the birth of the baby. This behavior manifests itself when the new mother looks for and seeks to preserve proximity and closeness with her infant. Beck (2006) and Nicolson (2002) have both shown that women who suffer from post-
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McMahon, Barnett, Kowalenko, and Tennant (2006) found that depressed mothers were more likely to have attachment issues with their infants and that their insecurity regarding motherhood further created an unsteady attachment process. Other studies have shown a correlation between maternal depression and infant sleep disturbances, feeding issues, increased temper tantrums, and later child behavior problems, including depression (Halligan, Murray, Martins, & Cooper, 2007). This negative impact is linked to the interruption of the maternal-infant attachment connection. The absence of joy while caring for the newborn, accompanied by unrelenting gloom and sorrow, can mean that the mother finds it difficult to give basic care to her newborn baby. In situations like this, the mother may ignore the baby’s vocalizations and smiles and does not spend time playing, talking, or vocalizing back to the baby (McLearn, Minkovitz, Strobino, Marks, & Hou, 2006). These women typically become so overwhelmed by the normal, everyday tasks of caring for a child that they build a wall around themselves. Women with postpartum depression continuously feel overwhelming guilt and anger, which may eventually lead to unreasonable thoughts.

Home with the baby all day, Stephanie became frustrated with the realities of child care. She felt as if Emma was controlling her life and she seemed lost in her new role, with no one to talk to. Stephanie became increasingly depressed. She stopped getting dressed in the mornings and even stopped showering. Stephanie went from fitful sporadic sleep to not sleeping at all. Even when the baby slept, Stephanie could not fall asleep. She would sometimes doze off, only to be awakened by a full-blown panic attack. Television shows and commercials portraying mothers lovingly holding and playing with their babies sent her into despair.

When Stephanie came to see me, she was somewhat disheveled in appearance. This appearance progressed to very disheveled over the first few sessions.

When the attachment process is disturbed, it can affect the infant’s cognitive, social, and emotional growth and development.

Her clothes were baggy, her hair was dirty, and she looked exhausted and scared. I noted that although other mothers would bring their infants with them to my office for therapy, Stephanie did not. Emma was always in the care of another relative. Stephanie said she thought she was somewhat unskilled in caring for her newborn and that’s why she preferred to come to her therapy sessions alone. Her husband came with her on two occasions, but even then Emma was in the care of others.

When I tried to encourage some social interactions with her newborn, Stephanie would respond that she often just stared at Emma. While other relatives laughed and cooed to the baby, Stephanie claimed that she did not know how and had no desire to do that. Some of her responses were “I don’t know what to say,” “Is it bad that I just stare at her?” and “Am I being a bad mother?” Fortunately for Stephanie, she had much family support, and Emma was receiving social contact from other family members.
Social interaction is fundamental in how infants learn; adults speak to babies and make sounds, and babies learn to differentiate those sounds and experience the warm relationships offered by the adults. Conversely, infants who continuously lack such interactions may develop attachment insecurity and be at risk for future deficits in cognitive, emotional, and behavioral competence (Beeber, 2002).

Stephanie complained of feelings of detachment from her newborn. She found herself obsessively worrying about the “right” thing to do with her baby. She would ask, “Am I doing the right thing by putting her down in the bouncy seat? Am I doing the right thing by putting her in the swing?” Her concerns about what is the “required” amount of time to interact with the baby became obsessive as well. “How much time should I spend talking to her?” “How long should I look at her for?” “Am I being a bad mother if I put her down while I do housework?” and “I feel like I am ignoring her when I am not interacting with her” were typical comments.

Comments such as these from Stephanie are an illustration of what Barr (2008) describes as “mechanical infant caring.” For Stephanie, her depressed state was causing her to become trapped in a way that was prohibiting her from completing the normal progression into the social role of motherhood (Barr, 2008). She seemed to have no instinctual parenting skills. According to Barr (2008), a new mother “learns” her new baby and the newborn responds accordingly, but when this doesn’t happen, the mother demonstrates mechanical infant caring, meeting the infant’s basic biological needs but little else. The lack of maternal-newborn attachment also can cause distress in the newborn, making the newborn fussy and irritable, which in turn causes the new mother more stress by having to cope with an irritable baby and her own depression and anxiety.

Stephanie’s symptoms were identified and addressed relatively early in the postpartum period. She was referred to me by her obstetrician, who prescribed Zoloft. I began talk therapy with her and added a benzodiazepine (Xanax) to her medication regimen until the SSRI became effective. She had ceased breastfeeding before coming to see me. Three months of intensive treatment and therapy followed by 3 to 6 months of weekly visits and phone calls led to the resolution of her symptoms.

During the difficult stages of her illness, her mother and mother-in-law served as Emma’s “mother by proxy.” They each provided a pair of loving arms and interacted with Emma consistently until Stephanie began to feel better. Through a support group and “Mommy and Me” classes, Stephanie was able to observe other mothers and how they were interacting with their babies. The class leader became a role model for her, teaching her interactive songs and ways to play with her baby. Throughout her recovery, Stephanie’s natural maternal instincts slowly began to emerge. With each new accomplishment, Stephanie was thrilled and even more excited as Emma began to respond to her.

Nursing Implications

Proper diagnosis and prompt treatment are extremely important in reversing the negative effects of postpartum depression. Screening for postpartum depression is crucial and should be a routine part of healthcare for new mothers (US Preventive Services Taskforce, 2002). Health advocates are working hard to bring the urgency to the attention of healthcare providers and new mothers (Beck, 2006; Truant, 2005). Postpartum depression screening tools have been well described in the literature (Beck, 2008; Beck & Gable, 2001), but screening tools are not considered diagnostic. Diagnosis of postpartum depression can only be accomplished through evaluation of the woman by a qualified provider who uses the formal criteria for postpartum depression in the gold standard DSM-IV.

Nurses who work with postpartum women should be aware of the screening tools for postpartum depression and should keep in mind some of the critical thinking questions and cues for observation contained in Table 1. Assessment followed by formal screening should allow the nurse to identify women who need to be referred for diagnosis and treatment. When implementing a treatment plan for postpartum mood disorders, it is important to assure the client of three basic facts: She will recover, she is not alone, and this is not her fault (Bennett & Indman, 2006). These women need the reassurance that with the proper care and treatment they will recover. Reminding them that they are good mothers and they need to take care of themselves in order to care for their infants is also essential.

Treatment of postpartum depression generally includes pharmacotherapy and psychotherapy. Psychotherapy should be accomplished with a clinician who has experience in caring for women with postpartum depression. Many psychotherapeutic approaches can be used, but the main focus should be dealing with the current crisis and eventually helping her gain a full recovery. In planning treatment, Abreu and Stuart (2005) noted that many breastfeeding mothers might choose psychotherapy over pharmacotherapy because of worry about medications and breastfeeding. There are many benefits to breastfeeding, and for mothers who want to breastfeed, the mother-infant bonding potential with breastfeeding cannot be ignored (Eiberhard-Gran, Eskild, & Opjordsmoen, 2006). Choice of medication for treatment should be made by a provider who has a thorough knowledge of the pharmacology of antidepressants and how they might interact with breast milk. Selective serotonin reuptake inhibitors (SSRIs) are often the first line of treatment, except for fluoxetine (Eiberhard-Gran et al., 2006). Tricyclic antidepressants are the second choice and, except for doxepin, are considered to be an ac-
ceptable option for breastfeeding women (Eiberhard-Gran et al., 2006). Monoamine oxidase inhibitors are generally not recommended because little is known about their effect on breast milk (Eiberhard-Gran et al., 2006). There is still a lack of sufficient data regarding the safety of all antidepressants during breastfeeding; however, some researchers have suggested that the exposure to the fetus in utero is higher than exposure to the newborn during breastfeeding (Eiberhard-Gran et al., 2006).

Self-care for women who suffer from postpartum depression includes diet, rest, and exercise. It has been suggested that women who suffer from postpartum depression should reduce their intake of carbohydrates, sugars, and caffeine and increase their intake of protein (Saldeen & Saldeen, 2004). Research has found that adding vitamin B6 and alpha omega-3 fatty acids to the diet can reduce the symptoms of postpartum depression (Saldeen & Saldeen, 2004).

Ross, Murray, and Steiner (2005) suggest that good, quality nighttime sleep is key in the recovery process from postpartum depression. The nurse who cares for this mother, therefore, should enlist the help of family members so the new mother can get 7 to 8 hours of uninterrupted sleep. The breastfeeding mother should be encouraged to express milk throughout the day to use for the nighttime feedings when others are caring for the newborn.

### Interventions to Facilitate Reattachment

Much is known about detection and treatment of postpartum depression, but less is known about interventions to facilitate reattachment. Beck (1996) discussed the concept of “mother by proxy” as a method of securing attachment in the newborn. This means that extended family or friends can be recruited to help embrace, hold, and interact with the infant so the infant is not deprived of warmth, love, and affection. For older children, Beck (1996) suggested not allowing them to see their mother crying or distressed.

Armstrong et al. (2000) evaluated a home-based intervention that encouraged the re-establishment of maternal-infant attachment in families. Nurse practitioners made home visits for mothers suffering from postpartum depression and guided these women in attaching and communicating with their newborns. The nurses worked to enhance the self-esteem of the mother by continuously emphasizing any successful attempts at bonding. They provided anticipatory guidance and education regarding the normal development of the infant and assisted the mothers in dealing with problems such as crying or erratic sleep patterns. This intervention of nursing care in the home was successful in the infant’s response to the parent, which, in turn, caused the mother to feel more confident in her caretaking role.

Horowitz and colleagues (2001) conducted a study on interactive coaching to facilitate the maternal-newborn bonding experience. Interactive coaching provided the new mother with skills to identify her infant’s signals and cues and taught positioning, use of facial expressions, and tactile and vocal stimulation as ways to facilitate bonding. Field, Hernandez-Reif, Diego, Schanberg, and Kuhn (2005) discussed the advantages of infant massage as a form of intervention in treating the depressed mother and her newborn. Not only can massage therapy reduce the mother’s symptoms of depression and anxiety, but it also can help the mother engage her infant and facilitate the attachment process. Gentle massage techniques that the mother can perform on her newborn help improve the mood of mother

### TABLE 1. Critical Thinking for Nurses to Assess the New Mother

<table>
<thead>
<tr>
<th>What to look for</th>
<th>What to ask</th>
<th>Warning signs in the baby</th>
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<tbody>
<tr>
<td>Missed appointments</td>
<td>How are you doing?</td>
<td>Irritable, fussy</td>
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<tr>
<td>Excessive worrying</td>
<td>Do you have any particular concerns?</td>
<td>Inappropriate weight for age</td>
</tr>
<tr>
<td>Disheveled appearance</td>
<td>How are you sleeping? How much?</td>
<td>(too much, too little)</td>
</tr>
<tr>
<td>Appearing unusually fatigued</td>
<td>Have you had any strange thoughts?</td>
<td>Problems breastfeeding/bottle feeding</td>
</tr>
<tr>
<td>Major loss or gain of weight</td>
<td>Are you getting help at home? With the baby? Housework?</td>
<td>Does not respond well to social contact</td>
</tr>
<tr>
<td>Problems with breastfeeding</td>
<td>How is the breastfeeding/bottle feeding going?</td>
<td>Does not respond appropriately to the mother</td>
</tr>
<tr>
<td>Problems handling the newborn</td>
<td>Did you begin menstruating yet?</td>
<td>Poor visual contact with mother or others</td>
</tr>
<tr>
<td>Mood is angry, irritable, or flat affect</td>
<td>How is your appetite?</td>
<td>Weak communication</td>
</tr>
<tr>
<td>Missing important cues with the baby</td>
<td>How much caffeine are you drinking?</td>
<td>Older child—delayed cognitive or verbal skills</td>
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<tr>
<td>Holding the baby in a mechanical manner</td>
<td>How are you feeling about motherhood in general?</td>
<td></td>
</tr>
<tr>
<td>Appears awkward with the baby</td>
<td>Have you been having mood swings?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weepy? Anxious? Sad?</td>
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When working with a mother who suffers from postpartum depression, reassure the mother that she will get better; she is not alone, and this is not her fault.

and baby and, through tactile stimulation, promote the reattachment phase (Underdown, Barlow, Chung, & Stewart-Brown, 2006).

In addition to using routine therapy and treatment, Barr (2008) developed a “mentor” plan to help women who are experiencing postpartum depression. This plan consisted of having a mother who had formerly experienced postpartum depression act as a role model. These women played an important part in the reattachment process because they were able to empathize with the new mother.

Conclusions
Postpartum depression does not just affect the mother. The disorder carries with it implications for infant-mother attachment and future child development. The patient in this case study was lucky to be diagnosed early in the postpartum period and treated appropriately. Nurses should be aware of how important it is to screen postpartum women for depressive symptoms and help those women with positive screening test results to obtain treatment. Nurses can help new mothers overcome postpartum depression and learn to enjoy their newborns and their lives.

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References