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Is early, high-quality daycare an asset for the children of low-income, depressed mothers?

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Abstract

This paper reviews the relations found in the literature among poverty, maternal depression, early intervention, and child developmental outcome and a theoretical model is suggested. Mother–child transactional processes have been found to be impaired under conditions of poverty and maternal depression, leading to non-optimal outcomes in children. The first 2 years of life are particularly sensitive to deficits in parenting, suggesting that effective intervention might appropriately target this age group. High-quality daycare may offer an effective pathway for intervention with depressed mothers and their children due to the compensatory caregiving children receive and the opportunity for early identification of maternal mental health needs. However, most current daycare intervention programs are designed to begin between 3 or 4 years of age. Further research that addresses the relative efficacy of interventions dependent on "age of entry" is needed to determine whether early daycare is an asset to families with a depressed caregiver.

The effects of maternal depression, both during pregnancy and during a child's early development, have been intensively investigated within the last 20 years. Due to growing evidence that the offspring of depressed mothers show significant developmental differences when compared to children of non-depressed mothers, maternal

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depression has become a meaningful construct for researchers seeking to understand its contribution to the trajectory of child development. Marked by dysregulated affect and affective distress, depression is relatively common with prevalence rates for women in the general population resting at approximately 8–10%, rising to 8–12% for mothers (Campbell & Cohn, 1991; O'Hara, 1986; Weissman, Leaf, & Bruce, 1987). Maternal depression represents a salient developmental concern as it has been found to disturb mother–child relationships during the first years of life, a developmental period which has become increasingly accepted as laying the foundation for the future development of self-regulatory, cognitive, and social competencies (Brooks-Gunn, Berlin, & Fuligni, 2000).

Depression, which is typically marked by feelings such as hopelessness, fatigue, irritability, and self-absorption, may manifest among mothers in the form of less sensitive and responsive parenting, as well as leading to higher maternal negativity, impaired communication, and diminished emotional involvement. Impaired parenting qualities, in turn, place children at risk for a myriad of developmental problems including poorer regulation of negative affect, less reciprocity and mutual positive affect, lower rates of compliance, lower levels of vocalization and activity, and less interest in interacting with inanimate objects (Ashman & Dawson, 2002; NICHD, 1999). It should be noted at this point, that depression does not represent a unitary construct, but instead manifests itself in many different forms including unipolar and bipolar affective disorders. However, for the purposes of this paper, it is the chronic presence of symptomology, rather than the diagnosis per se, that is the critical component thought to impair parenting. In addition, the effects of maternal depression on child development seem to be amplified for mothers and children who live under economically disadvantaged circumstances, perhaps due to a number of factors that make parenting more difficult such as single parenthood, lower levels of social support, and inability to afford services that might alleviate stress (Field, 1992; Lovejoy, Graczyk, O'Hare, & Neuman, 2000). Petterson and Albers (2001) found that affluence seems to buffer children from the negative consequences of maternal depression, a finding attributable to the greater resources (social, educational, and material) that may, perhaps, help mothers to maintain higher quality interactions with their children.

Not only does poverty seem to intensify the impact of maternal depression on child development, but it also seems to increase the sheer percentages of mothers who are affected by depressive symptomology (Orr & James, 1984). Maternal depression has been reported to co-occur with poverty status at elevated rates and to be, perhaps, the most critical mediator of the quality of mother–child interactions observed in early life (Aber, Jones, & Cohen, 2000). In evaluating data from the Infant Health and Development Program, Liaw and Brooks-Gunn (1994) found that whereas 17% of non-poor mothers reported high-depression scores, a full 28% of poor mothers indicated elevated levels of depressive symptomology. Two recent studies independently reported even higher percentages of elevated depressive symptomology among their low-income samples with close to 40% of the mothers reporting high levels of depressive symptomology on the CES-D (Loeb, Fuller, Kagan, & Carrol, 2004; Papero, 2004). Additionally, the Administration on Children, Youth, and Families found that primary caregivers for children enrolled in Head Start programs, which are