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Treatment – Mother–infant relationship psychotherapy

Antoine Guedeney, MD, Professor of Child & Adolescent Psychiatry [a, *], Nicole Guedeney, MD, PhD Sci, Child Psychiatrist [b], Jaqueline Wendland, PhD, Adjuct Professor of Psychology [c, d], Nina Burtchen, MD PhD, Pediatrician, Researcher [e]

[a] *Hospital Bichat Claude Bernard APHP, University Denis Diderot Paris 7, Policlinique Ney, 124 blvd Ney, Paris 75018, France*
[b] *Institut Mutualiste Monsouris, Paris, France*
[c] *University Paris Descartes, Psychopathology and Health Processes Laboratory, France*
[d] *Department of Child and Adolescent Psychiatry, Pitié-Salpêtrière Hospital, Institute of Psychology, Paris, France*
[e] *Columbia University, New York, USA*

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In this chapter, we briefly describe several modes of parent–infant-psychotherapy, an efficient way of treating parent–infant relationship disorders. We then focus on treatment for postnatally depressed mothers. Perinatal depression defines an episode of major or minor depression occurring during pregnancy or the first 12 months after birth. Attachment-based parent–infant interventions are particularly helpful in the context of maternal perinatal depression, as postpartum depression has a special link with unresolved trauma and losses in the mother's childhood. The goal of treatment is to improve the mother's mood but also to prevent or reduce the effects of postpartum depression on the child. Infants of perinatally depressed mothers are at risk for a large array of negative outcomes, including attachment insecurity (particularly disorganised attachment), social-skills deficits, cognitive difficulties, behaviour problems, and later psychopathology. The 'ghosts in the nursery' concept refers to the painful or disturbed early childhood experiences coming from the mother's past, which haunt the present mother–infant relationship. By addressing the mother's unresolved attachment conflicts (in her relationship to her own parents), it is believed that the

* Corresponding author. Tel.: +33 1 42 55 89 50l; Fax: +33 1 42 55 89 53.
E-mail addresses: antoine.guedeney@bch.aphp.fr, guedeney@free.fr (A. Guedeney).

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development of a more adaptive parenting and a more secure and less disorganised attachment between the mother and her infant is facilitated. Changes in parent– infant interaction are not dependent on the port of entry (e.g. child's behaviour, parent's representation or parent–infant relationship). The perspective of attachment is key to install a therapeutic alliance with parents.

Introduction

In this chapter, we focus on the issue of mother–infant relationship psychotherapy with perinatally depressed mothers, as prenatal and postnatal depression is the perinatal disorder most thoroughly understood from a research perspective [1]. More specifically, we address key questions that perinatal practitioners may face in their routine clinical work with new mothers and their infants. Why should we engage in parent–infant psychotherapy for depressed mothers? What is the scope of parent–infant psychotherapy? What kinds of therapy are currently available for perinatally depressed mothers? We then focus on the concept of attachment from the infant's perspective, and of caregiving, including bonding issues, from the mother's perspective. Infant–mother psychotherapy for perinatally depressed mothers has mainly been studied by attachment theorists and attachment–informed therapists. The relationship between maternal attachment, postnatal depression, and caregiving and infant's attachment system can best be understood in a developmental and transactional model, in which timing of events, number of risk factors, and number of resilience factors are all taken into account [2–4]. Attachment-based parent–infant models are particularly helpful in the context of maternal perinatal depression. Perinatal depression is a particularly complex situation, but its relation to unresolved trauma and losses in the mother's childhood is clear [5–13] One of the main goals for research in psychotherapy for mother–infant attachment is to bridge the gap between research and clinical practice, as we have to establish the best practice parameters for perinatally depressed mothers and their infants [14]. The 'attachment component' is particularly strong in the conceptual model, which focuses on psychodynamics as an underlying factor of postpartum depression (compared with solely 'hormonal factors'), as attachment-based interventions have shown greatest effectiveness and efficiency in the treatment of perinatal depressive disorders.

Perinatally depressed mothers and the risks of child-negative outcomes

The evidence-based report of the US Agency of Health Care Research and Quality proposed the notion of postnatal depression to define an episode of major or minor depression occurring during pregnancy or the first 12 months after birth [15]. Perinatal depression (prenatal and postnatal depression) is a complex situation, involving the (future) mother but also a developing infant and, to some extent, the whole family [5,6]. This complexity calls for an integrated and shared work of perinatal health practitioners, as well as for the development of new treatment modalities (i.e. parent–infant groups, parent–infant co-therapy [Wendland J, unpublished data]). In the first book on parenthood and mental health [7], jointly edited by infant and adult psychiatrists, Cox and Barton highlight the necessity of collaborating between adult psychiatric teams and infant mental health professionals [16].

Several meta-analyses [2,17,18] have confirmed that infants of perinatally depressed mothers are at risk for a large array of negative outcomes, including attachment insecurity (particularly disorganised attachment), social skills deficits, cognitive difficulties, behaviour problems, and later psychopathology [19]. According to Forman et al. [20], one hypothesised pathway for transmission of risk is parenting. Therefore, special attention should be given to infant–mother psychotherapy. In a meta-analysis, Lovejoy et al. [21] confirmed that parenting of depressed mothers can be largely affected by their mental condition. Goodman and Brand [19] found that, in perinatally depressed mothers, the following was more frequent in parenting compared with non-depressed mothers: negative maternal affects (less positive behaviours); hostile behaviours (e.g. disrupted affective communication, and negative or coercive behaviours); withdrawal behaviour (e.g. disengagement and abdicative behaviour) or inconsistency (e.g. insensitivity) in parenting is more frequent with perinatally depressed mothers than with non-depressed