Early Parenting Difficulties: Implications for Health Services Policy

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Australia’s residential early parenting centres are unique internationally and provide a highly valued service to parents and their very young children. Clinical practice in these services has been based on extensive experience, but now needs to be derived from an evidence base. In response to this need, Tweddle Child and Family Health Service (TCFHS) in Melbourne — a public access early parenting service — commissioned a review of the literature relating to its practice and a prospective longitudinal survey of a consecutive group of mothers admitted with infants aged up to one year. This article summarises the main findings of both the literature review and the survey.

Australia’s public access residential early parenting centres are a unique national resource and were established initially for the care of abandoned, relinquished or mistreated young children. Over time their purpose and function has altered to reflect social change associated with reduction in relinquishment of children for adoption, and policies that have sought to minimise removal of children from parental care. Now they focus on assisting parents to improve caretaking capacity. There are no equivalent services in any other country in the world. In general, services for parents experiencing difficulty caring for infants in industrialised countries are based in primary health care or outreach home visiting services. Consumer satisfaction surveys indicate that parents value early parenting services highly, but as yet there is a limited evidence base to their clinical practice.

Mental and Reproductive Health of Mothers Admitted to Early Parenting Centres

A search of the literature found a small group of studies had investigated the mood, reproductive health, social circumstances and problems of mothers and infants attending these Australian residential services. The findings of these studies are difficult to compare because different methods of data collection were used and few included comparisons with untreated groups or population data.

Most assessed mood by the widely used self-report Edinburgh Postnatal Depression Scale (EPDS) (Cox et al. 1987). This 10-item questionnaire has established psychometric properties and yields a score between 0 and 30; scores of more than 12 indicate clinical significant symptoms of depression warranting additional professional care.

All mothers admitted to public access residential early parenting services with babies aged up to one year are distressed, but research has focused on depression. These studies have not elucidated the psychological distress experienced by women seeking admission whose scores were not in the EPDS clinical range (see Table 1).

Table 1. Clinically significant depression symptoms in women admitted to public access residential early parenting services

<table>
<thead>
<tr>
<th>Early parenting service</th>
<th>Number in study</th>
<th>% of participants with EPDS* or CES–D# scores in the clinical range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karitane, NSW</td>
<td>92</td>
<td>41%*</td>
</tr>
<tr>
<td>Karitane, NSW</td>
<td>100</td>
<td>39% *</td>
</tr>
<tr>
<td>Torrens House, SA</td>
<td>20</td>
<td>70% *</td>
</tr>
<tr>
<td>Riverton Centre, QLD</td>
<td>47</td>
<td>60% *</td>
</tr>
<tr>
<td>Tresillian, NSW</td>
<td>72</td>
<td>36% *</td>
</tr>
</tbody>
</table>

* Edinburgh Postnatal Depression Scale (Cox et al. 1987)
# Centre for Epidemiological Studies – Depression Scale (Andersen et al. 1994)
Building on these studies Fisher et al. (2002b), in 1997, surveyed 146 women admitted with their infants to Masada Private Hospital Mother Baby Unit (MPHMBU), one of the first private residential early parenting centres in Victoria. They found that psychological distress was multifaceted. While 48% had EPDS scores greater than 12, almost all (91%) had severe occupational fatigue and were clinically exhausted, and 45% had disabling anxiety especially about infant care.

Studies, which assessed participants’ reproductive health, found rates of previous reproductive events that appeared higher than general population rates. In Barnett et al. (1993) 3% of participants reported a past ectopic pregnancy, 2% a previous stillbirth or neonatal death, and 9% experienced infertility. Fisher et al. (2002a) also found apparently elevated rates of previous stillbirth (1.3% compared to 0.71% in the general population); past ectopic pregnancy (1.3% compared to 0.5%); IVF conception (6.5% compared to 1.1%); invasive prenatal testing (25% compared to 9%); and caesarean or forceps-assisted birth (53% compared to 29.4%). Many participants (52%) perceived their postnatal obstetric care as unsatisfactory in relation to post-delivery pain control, breastfeeding education, sufficient rest and a long enough stay. One other study reported that 39% of births were caesarean deliveries (Leeson et al. 1994).

**Behaviour of Infants Admitted with their Mothers to Early Parenting Centres**

Problematic infant behaviours are the most common reason for parents to seek assistance from early parenting services.

In the Karitane group 96% of the infants had either feeding difficulties, periods of inconsolable crying or dysregulated sleeping, or a combination of these conditions (Barnett et al. 1993). Parents kept infant behaviour diaries prior to admission to Torrens House and the 23 infants woke frequently to have an average of seven milk feeds overnight, and resisted being settled (Leeson et al. 1994). Overall, 72% of the infants at the Riverton Centre woke more than three times per night and 83% slept for less than two hours during the day (Armstrong et al. 1998). Twenty-four hour infant behaviour charts, collected from 109 mothers one week prior to admission to Tresillian Family Care Centres’ Willoughby Unit in NSW, showed that, on average, the infants cried and fussed for 3.6 hours in 24 hours (Don et al. 2002). Two groups of infants admitted to MPHMBU, aged four months to a year, were found to have dysregulated behaviour including waking more than twice overnight (66%, 64%), rarely or never self-settling (90%, 93%), and had total daytime sleep of less than two hours (55%, 78%). A third had feeding difficulties, including refusal of breast, bottle or solid foods or mothers with an insufficient supply of breast milk. The mothers of one of these groups completed 24-hour infant behaviour diaries and on average, the babies cried or fussed for 2.5 hours during the 24 hours. Diagnoses of gastro-oesophageal reflux had been made in 16% of the infants admitted to Torrens House and a third of those admitted at both the Riverton and MPHMBU.
Mary, John and baby David

Mary was a manager in a large retail store, when she met her partner John in her early thirties. They had delayed having a baby in order to buy a house and travel, but found it difficult to conceive. They embarked on IVF, with all its intrusions and disappointments, and in time Mary conceived. Pregnancy was relatively uneventful and as Mary’s elation at having a baby continued; she imagined that she would feel overjoyed and complete when her baby was born. Labour began spontaneously, but foetal distress was diagnosed and baby David was ultimately born by an emergency caesarean. Mary remained in the recovery ward while her newborn was taken to the Special Care Nursery accompanied by his father. To Mary this separation lasted hours, and when finally re-united with her baby she wondered whether he was hers because she had not seen him for long in the operating theatre. Breastfeeding was painful and very difficult with a bout of mastitis and lots of worry about whether the baby was getting any milk. This baby was not born into an empty space, but into real lives. John worked on short-term contracts in the IT industry and, just as Mary went on maternity leave, his contract ended. He was pretty concerned, but dealt with this by spending hours on the computer ostensibly job-hunting, but apparently playing games. As the weeks went by Mary became increasingly worried that she would have to resume employment much earlier than planned in order to support the family. Mary’s mother lived in the country and was employed full-time so was only able to talk to Mary on the telephone and visit occasionally. Mary was 39 when she had David and most of her friends either had no children or children at school; she did not know other mothers of newborns. Mary’s caesarean wound took a long time to heal and was still tender; she was also conscious of urinary incontinence when she lifted her baby. John thought that mothers did all the housework and infant care because his mother had looked after four children and never complained.

Like many newborns, baby David was unpredictable. Sometimes he slept for an hour, but most often for short naps of 20 minutes. He cried a lot and Mary felt unable to comfort him. She breastfed him “on demand” — which was as often as 15 times in 24 hours — with six or seven feeds overnight. She worried that he was hungry, but had read about colic and reflux and thought perhaps that he was in pain. There were whole days when she held the baby in her arms. John was critical of Mary because she did not know why the baby was crying and did not stop it. He expected her to work it all out.

Mary found herself feeling overwhelmed and sometimes irritable with John and the baby. She cried more than usual, felt incompetent, increasingly desperate and as though the baby did not like her much; she wondered if she had bonded with him. Her sleep got worse and she became hypervigilant and unable to go back to sleep after feeding David overnight. She was so tired that her driving deteriorated and there were a few near misses in the traffic.

Mary did not know who to talk to about her predicament. Her maternal and child health nurse was always busy and focused mostly on measuring the baby’s weight and height. She went to her general practitioner to talk about the baby’s unsettled behaviour and prolonged crying and he thought that she was depressed and suggested antidepressants. However, recently another of his patients had completed a residential program at an early parenting centre and he gave Mary the phone number at the same time as the prescription.

Mary rang, learnt of the waiting list, but a few weeks later completed the program. Over a five-day period, she learnt from the staff that her baby might be “under-slept” and exhausted; that infants need to learn to sleep and that there are strategies to support babies in learning this life skill. She was given opportunities to practice these settling and soothing strategies with support from staff who seemed calm, confident and experienced. She met other women who were finding the realities of mothering a newborn more difficult than had been imagined.

During group discussions they learnt some new concepts: about the need for partners to re-negotiate the paid and unpaid workload after the birth of a baby and about building collegial relationships with other mothers of newborns. She learnt that new ways of socialising were needed and that coffee mornings are just like staff meetings, not frivolous indulgences. She realised how much she lost in having a baby; that the infertility might have led her to have idealised notions about motherhood and that the difficulties at David’s birth and with breastfeeding diminished her confidence in her capacity to mother. John was asked by the staff to practice settling baby David and found it was not so easy. He became quite flustered, but was helped to persist. Mary and John were given a night out together, began to talk and realised that this new life phase required adaptation from them both.

After four days everyone’s mood improved, baby David slept and then smiled more and Mary’s breast milk supply increased. John talked about other options for getting work and also accepted that he had domestic obligations too. Mary’s feelings of affection for baby David blossomed and she began to feel that she was an effective mother.
Survey of Mothers and Infants Admitted to Tweddle Child and Family Health Service

For the TCFHS survey, English-speaking women admitted to the residential program with a baby aged less than one year between April and August 2002 were invited to complete self-report questionnaires about their health and circumstances. In total 62% of women invited decided to participate (Fisher & Rowe 2005).

The mental health of the participants was poor, with 39% having EPDS scores greater than 12 and 21% endorsing the item about ideas of self-harm. Overall, 80% were sleeping fewer than six hours per night, 69% had severe fatigue, and 20% disabling anxiety.

Reproductive health also appeared more difficult than average for these participants. The rates of previous stillbirth (5.9%), ectopic pregnancy (3.9%), pregnancy termination for foetal abnormality (5.8%), IVF conception (6.3%) and births by caesarean surgery or with forceps assistance (44%) were all higher than rates for the general population. At admission there were high rates of persistent childbirth-related health conditions including unhealed or infected caesarean or episiotomy wounds (19%); problems with bowel control (26%) and urinary incontinence (18%).

The infants were very unsettled with 77% described as having very poor sleep, 76% waking more than twice in the night, and sleeping a total of two hours or less during the day. They cried for an average of 2.7 hours in a day and feeding problems were common.

Residential early parenting programs recognise that psychological distress following the birth of an infant is governed by multiple factors and aim to treat mother, infant and the mother-infant relationship. Treatment is non-pharmacological and therefore acceptable to mothers — especially those who are breast-feeding — and less stigmatising than admission to psychiatric facilities. Many women lack knowledge about infant behaviour, development and temperament and feel under-skilled in infant care, especially if the baby is unsettled and cries inconsolably. The programs provide specific information and focus on skill development through opportunities to learn with professional support in a safe setting. Increasing maternal knowledge, sensitivity and skills leads to improved mother-infant attachment. Overall, 83% of the participants felt helped and supported by the TCFHS program (see box for case study).

Conclusion and Policy Implications

The findings of the recent TCFHS survey are consistent with existing evidence and suggest the need for a broader definition of maternal mood disturbance after childbirth. Limiting the assessment of maternal mood to symptoms of depression fails to recognise the clinical significance of occupational fatigue, anxiety about infant care and poor physical health, which reduces maternal quality of life and requires professional recognition and appropriately tailored interventions. Persistent psychological consequences of reproductive losses, infertility and assisted conception, and operative interventions in childbirth need to be acknowledged with sensitivity. Unsettled infant behaviour, including prolonged crying, frequent overnight waking and resistance to soothing contribute to maternal fatigue and reduce maternal confidence and sense of efficacy. Reproductive health and infant behaviour should be assessed routinely in mothers who are distressed.

Currently there is a national policy emphasis on early parenting, with governments establishing early intervention initiatives to support parents. The federal government’s National Agenda for Early Childhood and $70 million Stronger Families and Communities Strategy (2004–2008) emphasise prevention and early intervention (www.facs.gov.au). The Victorian government’s Best Start program aims to improve the “health, development, learning and wellbeing of children...from pregnancy through transition to school” and includes better access to programs that improve the parenting experience.
(www.beststart.vic.gov.au/). Despite this, services such as TCHFS operate in an uncertain funding environment.

Australia’s residential early parenting services provide a highly valued intervention that assists mothers and infants whose wellbeing is adversely affected by poor reproductive health and unsettled infant behaviour. These services offer short-term, low stigma non-pharmacological programs, which constitute an important component of national and state early intervention policies.

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References


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