A Window into Perinatal Depression
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NMAIMH competencies addressed
Theoretical Foundations
- pregnancy & early parenthood
- family relationships & dynamics
Direct Service Skills
- observation & listening
- screening & assessment

Depression often is an isolating condition. Many feel ashamed or worried they will be judged for feelings that they may not fully understand nor desire. In today’s society, although we are improving each day on destigmatizing depression, we are still not there yet. That pressure only intensifies when a family is expecting a baby or has welcomed a new baby into their lives.

Some statistics to put things into perspective:

- “Globally, an estimated 350 million people of all ages suffer from depression (Anxiety and Depression Association of America, 2016).”

- “Nearly 15 million Americans – one in 10 adults – experience depression each year, about two-thirds don’t get the help they need.

- At least 13% of women experience major depressive disorder (MDD) while pregnant and 11–20% experience post-partum depressive symptoms (Muzik & Borovska, 2010).

- For fathers, the average rate of depression is 10.4% during their child’s first year of life. This is approximately double the rate for depression in adult males (4-5%) (Maternal, Infant, and Early Childhood Home Visiting Program Technical Assistance Coordinating Center, 2013).
What we know about perinatal depression is that it affects the whole family. There is a correlation between a mother’s depressive symptoms and a father’s depressive symptoms, which shows that when one parent’s symptoms increased, so does the other parent’s (Maternal, Infant, and Early Childhood Home Visiting Program Technical Assistance Coordinating Center, 2013). Prenatally, depression can lead to missed prenatal visits and using harmful substances (alcohol, tobacco, drugs). Depression during pregnancy can increase the risk of having a low birth weight baby or a premature birth (Office on Women’s Health, 2016). Postnatally, depression can negatively impact parent-infant bonding, with increased risk of delays in cognitive, language, and social emotional development (Muzik & Borovska, 2010).

In our work supporting home visiting families dealing with perinatal depression, what does that look like? Our role facilitating the parent-child relationship would not change, but we may pay closer attention to it. For example, if a parent is having difficulty experiencing joy, pointing out when the parent and infant shared a special moment could help shift that parent’s focus to notice what is working well. Also, how can we “hold” that parent from a nurturing and attentive perspective, so they are better able to “hold” their infant and be the kind of parent they want to be in spite of their depression ("Circle of Security," n.d.). As in the words of Emily Dickinson:

“Hope is the thing with feathers –
That perches in the soul –
And sings the tune without the words –
And never stops – at all”

Questions to encourage discussion and reflection…

- How do we have those conversations with mothers and fathers during pregnancy and postpartum about how they are feeling?
- How do we know when to refer a parent for mental health services?
- How do we follow our gut and have a discussion about referring when we feel something is not right, but the Edinburgh Postnatal Depression Scale (EPDS) indicates otherwise?
- How do we tap into a parent’s own strengths, motivation, and current support system? How do we help that parent expand their circle of support formally and informally?
- How do we value a parent’s cultural beliefs regarding depression while exploring additional resources if desired?
- When will you know when you, as a home visitor, need support from your supervisor and others to best meet the needs of a particular family and to take care of yourself?
References/Additional Resources


