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Mental Health of Caregivers and Psychological/Emotional Development of their Children

Takashi OKADA
Department of Developmental Disorders, National Institute of Mental Health, National Center of Neurology and Psychiatry
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Abstract

Perinatal women often experience the onset or recurrence/relapse of psychiatric disorders. This results in limited parenting skills and an increased risk of them maltreating their children. In addition, care givers' mental health is also related to various psychosocial factors such as life history, process to get pregnant and deliver children, relationship with their spouse, social support, and economic status. Developmental disorders of their children may also increase difficulties in parenting and disturb the emotional relationship or communication between caregivers and their children. Maltreatment negatively impacts children's cognitive, emotional, and physical development, resulting in a worsening of emotional and behavioral problems and increased difficulties in parenting. The importance of medical care for pregnant women with psychiatric disorders is recognized; however, only a few medical facilities accept such patients. In these medical facilities, different nursing staff are placed in charge of mothers and their children depending on their status. It is important for psychiatrists to provide consistent care to pregnant women and cooperate with regional staff in health care or welfare.

Keywords: perinatal mental health, difficulties in parenting, maltreatment, developmental disorder, bonding

Introduction

In the perinatal period, there are high rates of new onset, relapse, and recurrence of various psychiatric disorders, including depression, [7] they are associated with a decreased quality of life in perinatal women [3] and suicides [1], and so the need to deal with them has been recognized. In addition to the introduction of the Edinburgh Postnatal Depression Scale (EPDS) in postpartum health checkups and inclusion of "patients with psychiatric disorders" in high-risk pregnancies and deliveries, a new high-risk maternal guidance fee was established. The fact that not only obstetricians and psychiatrists but also municipal or prefectural government officials were invited to participate in the conference as members of the calculation requirement represents recognition of the importance of the mental health of perinatal women and importance of cooperation between obstetric care, psychiatric care, and regional maternal and child health care to resolve this issue. The target of perinatal mental health is not only maternity blues and postpartum depression, but also mental health during pregnancy and pregnancy complicated by psychiatric disorders, and cooperation is required to realize support.

However, there are only a few obstetric care institutions that can deal with pregnancies complicated by psychiatric disorders, and the reality is that these cases are handled at general hospitals that provide advanced obstetric care. In many cases, mental health care is provided within the framework of liaison consultation, away from the primary psychiatrist in the community. In addition, because the establishment of general perinatal medical centers requires the assignment of clinical psychologists, clinical psychologists affiliated with general hospitals are involved in psychological care in cases of stillbirths, neonatal deaths, and those involving a child recognized as having a medical disorder or expected to die prematurely. In other words, psychiatric or psychological care is provided through in-hospital collaboration, and cooperation between obstetrics and psychiatric medical institutions in the community is limited to the provision of new community care after discharge based on information provided in the medical information form and community personnel who participated in the conference during hospitalization, and cooperation with inpatient care is insufficient.

Another reason why perinatal mental health is considered important is that it is associated with restrictions on child-rearing ability and the risk of abuse [5]. In obstetric and neonatal care, priority tends to be given to child protection and psychiatric treatment of parents, and assessment of the parenting ability of parents with psychiatric disorders is uniformly regarded as difficult. However, patients with psychiatric disorders have a variety of medical conditions, and above all, they do not raise their children alone. It is necessary to reflect on the patient's wishes and those of the family as much as possible by taking into account the current state of social support and community support, and the role of the attending psychiatrist is significant in this process. In such cases, the mother and child health care and mental health and welfare should work together to support the patient's rearing of a child with a psychiatric disorder, but the extent to which support is provided varies among cases.

The presence or severity of a psychiatric disorder does not directly lead to difficulties in parenting, but the lack of appropriate support for parenting or the inability to seek support despite difficulties in parenting increases such difficulties, and the problem should not be attributed solely to the patient's psychiatric disorder. Maltreatment not only causes difficulties in parenting and risks of abuse, but also has a significant impact on the psychological and emotional development of the child. On the other hand, if a child has physical or mental disabilities, including developmental disabilities, that increase difficulties in parenting, the need for support is even greater.

Recent studies suggest that caregivers' mental health is related to children's behavioral problems [6] and cognitive development [2]. Caregiver mental health and children's psychological and emotional development interact with each other. This paper focuses on the relationship between caregivers and children and the difficulties that exist in this relationship, and discusses what is necessary to support caregivers.

I. Parents' stories of pregnancy and childbirth

The story leading up to pregnancy and childbirth has changed markedly from the past. While the number of dual-earner families is increasing, the number of cases in which women are considering the timing of pregnancy and childbirth is also increasing due to social and economic circumstances, in which understanding of pregnancy and childbirth in the workplace and the taking of childcare leave for both sexes are still insufficient. In addition,

infertility treatment is widely available, and in many cases, couples have reached pregnancy and childbirth after considerable discussion, not only about the idea of having a child, but also about the economic aspects. These cases often include vague expectations about having a child. In some cases, they envision a family reunion, in others, they expect the child to be a "bond" between a married couple who are not getting along, and in other cases, they unconsciously entrust the child with a dream that the parents could not achieve. In some cases, the desire to have a baby is due to the succession of the family business or expectations and pressures of the parents. On the other hand, there are many different stories that lead to pregnancy, including cases in which the mother already has a child with a genetic disease or difficulties in parenting, and has been anxious about pregnancy and childbirth, as well as unexpected or unwanted pregnancies.

After pregnancy, dynamic changes occur at the hormonal level. Physical discomforts, such as hyperemesis gravidarum, are a reminder that a new life has been conceived, and the presence of the child is more realistic today, when the shape of the fetus and beating of its heart can be confirmed by ultrasound examinations. Although the mother and fetus are separated by the placental-blood barrier, some hormones pass through it, and heartbeats and fetal movements are related between the mother and fetus, indicating a synchronized relationship between them. It is considered that fantasies about the child are expanding and the "imaginary child," so to speak, is growing, and the parents actually begin to talk to the fetus in the belly after ultrasound examination or when fetal movements are felt.

Modern medicine poses a more complex problem. Ultrasound examinations not only monitor fetal development, but also serve as a prenatal fetal diagnosis, detecting cardiac malformations and suspected chromosomal abnormalities. Amniocentesis can detect the presence or absence of chromosomal abnormalities in the fetus. Amniocentesis is becoming more common as the childbearing age increases. However, it brings about complicated conflicts not only in terms of medical ethics but also as practical concerns for parents, such as whether to undergo the test and, even if one does undergo it, what to think in the case of detecting chromosomal abnormalities.

Thus, the relationship between parents and their children begins before birth, both biologically and psychologically, and leads to the parent-child bond. However, there are psychosocial problems and conflicts

caused by these problems surrounding childbirth. In such a context, the imaginary child is magnified, sometimes quite fantastically, sometimes quite symbolically. It is under these circumstances that the real child is born. In the postnatal period of sensitivity, the parents are immersed in the care of the real child and respond to the child's emotional promptings, deepening their bond with the child. However, there is always a gap between the imagined child and real child, and the more distant the imagined child is from reality, or the more unexpected the real situation is, the more difficult it is for the parents to adjust.

Some parents flinch at their child's disability after birth, expressing guilt that they are not able to give their child love, which is not lacking in any way, and anger at the reality that prevents them from giving their unreserved love. If a prenatal diagnosis has already revealed the presence of a disability, the couple may begin a new chapter in their lives with the hurt stemming from the hesitation they felt when they were informed of the possibility, disagreements between them, and the perceived inadequacy of their spouse during the process. In addition, conflicts between caregivers and their own parents often become apparent during pregnancy and childbirth. Complex conflicts over the caregiver's attachment to and care for the child, of which even the caregiver is unaware, can cast a shadow over their lives.

II. Interaction between caregivers and children and its obstacles

Appropriate parental caregiving behavior has a positive effect on children's cognitive, emotional, and behavioral development, while maltreatment has a negative effect on development and increases children's risk of developing psychiatric disorders in the future.

Maltreatment behaviors from parents may be caused by a variety of factors. Parents themselves may lack a parenting model because they were brought up in an abusive environment, and may not be able to take appropriate actions to cope with the difficulties that everyone faces in child-rearing, leading to undesirable parenting behaviors. Parent-Child Interaction Therapy (PCIT) [4], which has been spreading rapidly in Japan in recent years, is a treatment method that promotes behavioral change, and learning of appropriate parenting behaviors while providing an appropriate model for caregivers who are struggling with how to deal with the emotional and behavioral aspects of their children.

In addition, the psychosocial situation of the parents is also an obstacle to appropriate parenting behaviors [5]. For

example, lack of education, poverty, marital problems such as domestic violence and solo parenting, and lack of social support [8]. Maltreatment may cause emotional and behavioral problems in children, which in turn increases the difficulty of parenting, creating a vicious cycle. To prevent this, early detection and intervention are conducted by child guidance centers and public health nurses at local public health centers, but this support may not be sufficient or may be hindered by the family. Although seeking medical care can facilitate early detection and support, there are psychosocial conditions that prevent timely visits to medical institutions. It should be noted that many cases of abuse, which have become a problem in recent years, occur in families isolated from society.

In addition, as has been pointed out in the past, psychiatric disorders of caregivers can also be a cause of maltreatment [5]. Psychiatric disorders impair a sense of efficacy in parenting, increase parental hurt, and increase emotional responses to the child. This negatively affects the child's development and causes unstable emotional expression and behavioral problems, and parent-child interactions can easily fall into a vicious cycle. If the family can recognize this situation and provide appropriate support, the crisis can be avoided. In reality, however, if the family does not recognize the situation, or if they do recognize the situation but only blame the parent for his or her response, the parent will be further emotionally trapped, exacerbating the situation. Escalating emotional responses can lead to physical or psychological abuse, or neglect if the parent becomes indifferent to child rearing and fails to adopt appropriate parenting behaviors.

While psychiatric disorders are undeniably a risk factor for abuse, the presence of mental illness can also distort one's perception of reality in a more negative direction and reduce one's ability to perceive the situation, making one feel that one's parenting is less than it actually is. In addition, caregivers may be unable to recognize their children's emotional promptings due to psychiatric disorders, may only perceive intense emotional reactions and behaviors, and may feel as if their children are deliberately behaving in a way that annoys parents, such as being unreceptive and insubordinate. They also feel that their family is cold toward them and that they are alone. On the other hand, they are anxious about the future of their children, and therefore, in an attempt to do something about it, they find themselves acting emotionally and feel self-loathing. What is required here is the presence of people who recognize such a vicious cycle and

provide support, and medical care, welfare, and maternal and child health care must play a role in this.

On the other hand, the fact that a child has a developmental disability or presence of other difficulties in parenting has a significant impact on the parenting behavior of parents. A child with an autism spectrum disorder may not respond to a caregiver's efforts or may not make eye contact. They are also less likely to send signals of a need for help when they themselves are uncomfortable (e.g., hunger, toileting, cold/warmth, etc.). Therefore, caregivers provide care in a timely manner, but the children are unable to imagine the caregiver's mind, making it difficult for them to engage in reciprocal emotional interactions and objective relations. In addition, because of the difficulty of joint gazing, there are fewer opportunities for the caregiver to perceive the child's interests and initiate communication, or for the child to show or share his or her interests with the caregiver.

When children are able to walk on their own, they expand their behavior using their relationship with caregivers as a safe base. However, children with autism spectrum disorder perceive the presence of a caregiver as a sense of safety through sensory aspects such as touch and smell, rather than a sense of security under the gaze of a caregiver, and the loss of such a sense is easily perceived as anxiety. Even when children are physically separated from their caregivers, such as when they spend time at nursery schools or kindergartens, caregivers often go shopping or pick up their children while thinking of their children's faces. However, children with autism spectrum disorder are less likely to feel this kind of emotional connection, and they do not feel a sense of security. Therefore, children with autism spectrum disorder tend to have extreme separation anxiety because of increased anxiety at the time of physical separation from the caregiver, or they are at the other extreme of feeling no anxiety about separation from the caregiver because the interpersonal connection itself is weak. Under these circumstances, the caregiver may become exhausted from being followed around by the child, or may feel as if he or she is not wanted at all, leading to grieving.

Children with attention-deficit/hyperactivity disorder have difficulty controlling their speech and behavior, and their caregivers are troubled by the difficulty of disciplining them. They also have difficulty controlling their emotions, which often leads to tantrums. Children with autism spectrum disorder also often throw tantrums as a reaction to their

obsessiveness or novel situations. In such cases, caregivers tend to become exhausted because they cannot feel a sense of efficacy in nurturing the child. The presence of developmental disabilities is known to be a risk factor for abuse, but it has also been pointed out that abuse deteriorates the brain's emotional regulation and reward system functions, and is associated with attachment in early childhood, disruptive behavior in school-age children, trauma/dissociative reactions in adolescence, dissociative disorders/conduct disorders, and complex post-traumatic stress disorder in adulthood (developmental trauma disorder). These secondary effects may intensify difficulties in parenting and lead to mislearning of maltreatment behaviors and even intergenerational transmission.

III. Supporting the bond between caregiver and child

The relationship disorder between caregiver and child is not a problem that should be discussed only from the perspective of the caregiver's psychiatric disorder, nor is it a problem that should be discussed only from the perspective of the child's developmental disability or other difficulties in parenting. Nor should the impact of caregiver care on the child be addressed solely from the perspective of caregiver capacity or child protection. In a broad sense, caregiver mental health is related to a variety of psychosocial factors, including the caregiver's upbringing history, the story leading up to pregnancy and childbirth, inherent violence and discord between the married couple, as well as the caregiver's social support and community support system and medical care provision. It is also necessary to understand children's developmental disorders and emotional/behavioral problems from a multilayered perspective, including secondary problems that emerge during interactions with caregivers, in addition to children's innate characteristics. In other words, it is important to view the caregiver and child in the context of dynamism and how to support the bond that is nurtured between them.

However, what medical care can do in this context is limited. Psychiatry is involved in cases of psychiatric disorders, but in cases of high-risk pregnancies, the mother is transferred from the general obstetric ward to maternal-fetal intensive care unit (MFICU), and after delivery, the mother is transferred to the obstetric ward (or psychiatric ward for treatment of psychiatric disorders). Children are managed in the neonatal intensive care unit (NICU), then moved to the growing care unit (GCU), and consequently

discharged. During this process, wards and nursing staff members involved change rapidly in a short period of time. Psychiatrists and psychologists who are consistently involved with the patients play an important role, but it is difficult to establish a stable framework because the situation changes, including which ward to visit and whether the patient is in good physical condition to talk with them. Furthermore, if the patient returns to his/her original psychiatrist after discharge from the hospital, it is necessary to establish a close system of hospital and clinic collaboration there as well. In addition, considering life after discharge from the hospital, it is difficult and inappropriate for medical care alone to provide support, and it is essential to establish a system in which maternal and child health care and welfare play a major role in providing continuous support in cooperation.

While there is a movement to refrain from pregnancy due to the spread of COVID-19 infection, pregnant women are not able to see their families during the hospitalization period, and kangaroo care to meet with their newborns is also being hindered. In addition, there are many cases in which caregivers feel anxious about going out or feel mental health difficulties when raising their children at home, but are unable to go to see a doctor or seek advice. Although consultation services are available by telephone and online, it cannot be denied that the threshold for consultation has become higher. It should be noted that the need for support is increasing because it is difficult to receive support nowadays.

Conclusion

It has been widely recognized that the mental health of caregivers during the perinatal period affects child rearing and is associated with the risk of abuse. However, in many cases, the approach has been limited to psychiatric care for the caregivers and protection of the child, or, conversely, psychiatry has not been sufficiently involved, although it has been addressed within the framework of maternal and child health care. The mental health of caregivers and psychological and emotional development of children are mutually influential, and collaboration among multiple disciplines is essential. It is important that the involvement of psychiatry is not limited to the treatment of psychiatric disorders in the narrow sense of the term.

Addendum

This manuscript is a revised version of the presentation "Interaction between Mental Health of Mothers and Psychological and Emotional Development of their Children" at Symposium 40 "Mental Health of

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Conflicts of Interest (for the past three years)

Lecture fees, etc.: Shionogi K.K., Eli Lilly Japan K.K., Janssen Pharma K.K., Shire Japan K.K., Pfizer Japan Inc., and Mochida Pharmaceutical Co.

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