

Parenthood in the context of maternal depression at the end of the infant's first year of life

Parentalidade no contexto da depressão materna no final do primeiro ano de vida do bebê

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Abstract

The present study investigated parenthood in the context of maternal depression, at the end of the first year of the infant's life. The participants of the study were 22 families, from different socioeconomic levels, divided into two groups, one with mothers who did not present indicators of depression (n=12) and another group with mothers who did (n=10), based on the Beck Depression Inventory. All the mothers were primiparous and lived with the child's father, the babies were approximately 12 months of age. The mothers and fathers participated in an interview that investigated several parenting aspects. Qualitative content analysis of the interviews indicated that, compared to the group without depression, the depressed mothers, as well as their husbands, reported more difficulties regarding division tasks, financial concerns, and divergences and conflicts in child care. These results corroborate other studies which emphasized that the presence of indicators of maternal depression can cause difficulties in parenting.

Keywords: Fathers; Maternal depression; Parenting.

Resumo

O presente estudo investigou a parentalidade no contexto de depressão materna, no final do primeiro ano de vida do bebê. Participaram do estudo 22 famílias de diferentes níveis socioeconômicos, distribuídas em dois grupos: um cujas mães (n=10) apresentavam indicadores de depressão, e outro cujas mães (n=12) não os apresentavam, segundo o Inventário Beck de Depressão. Todas eram primíparas e viviam com o pai do bebê, que tinha em torno de 12 meses de

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idade. Mães e pais responderam a uma entrevista que investigou diversos aspectos da parentalidade. Análise de conteúdo qualitativa das entrevistas indicou que, quando comparadas ao grupo sem depressão, tanto as mães deprimidas como seus maridos relataram maiores dificuldades quanto à divisão de tarefas, preocupações financeiras e divergências e conflitos nos cuidados do filho. Esses resultados corroboram outros estudos que destacaram que a presença de indicadores de depressão materna pode trazer dificuldades para a parentalidade.

Palavras-chave: Pais; Depressão materna; Poder familiar.

The exercise of parenting requires a new form of family organization, both for the inclusion of the infant, and for performing the new tasks of caring for and raising children (Minuchin, 1982). Depression can have a negative influence on the parental relationship, since in the presence of this disorder it may be more difficult to adapt to new demands. Characteristically, maternal depression includes alterations in appetite and difficulty in sleeping, especially after feeding the infant, crying spells, inattention, difficulty in concentrating, and a lack of energy and interest in activities that were once considered enjoyable (Dunnewold, 1997). Suicidal ideation and excessive feelings of guilt may also occur.

Sometimes, the symptoms of maternal depression may be confused by the mother, companion and other family members with the natural fatigue and wear of the puerperium process, caused by the accumulation of household chores and the care given to the infant (Cruz, Simões, & Faisal-Cury, 2005; Nonacs & Cohen, 2005). According to Linares and Campo (2000), depressed people never equal to their illusions and expectations, experiencing feelings of guilt and frustration at being unable to fulfill their supposed responsibilities. This can make them try to deny their symptoms so as to maintain an apparent facade that there is no problem in their relationships and, in the case of depressed mothers, especially regarding the infant and their other relationships with their spouse and family of origin. Often, depressed mothers have a high level of demand and are very frustrated because they consider themselves unable to assume the multiple demands that arise after the infant is born, especially in relation to reconciling house care, the infant, and other children when this is the case (Frizzo, 2008).

Some depressed mothers may have their sadness and anguish minimized through infant care, however this demands a lot of effort from them (Schwengber & Piccinini, 2003). The mother suffers for herself and her infant, especially in an attempt to establish emotional contact, which may or may not be successful, and this suffering can assume great proportions (Likierman, 2003).

When there are no difficulties in mother-infant interaction, the mother carefully adjusts her behavior to that of the infant stimulating it adequately (Field, 1995). However, when the mother is depressed she may have more cognitive and emotional unavailability, which makes the contingency of the responses difficult and, consequently, affects her responsiveness to the infant (Frizzo & Piccinini, 2005). The infant may be, temporarily or permanently, deprived of the mother as an important external regulator of stimulation, which may cause failures in the development or maintenance of the modulation of excitement and in the organization of the infant's attentive and affective behavior of the child (Field, Healy, Goldstein, & Guthertz, 1990).

A study conducted by Frankel and Harmon (1996) investigated the relationship between maternal depression and mother-infant interaction through self-report instruments and observational data from 30 depressed and 32 non-depressed mothers in the United States. According to the authors, when mothers are depressed, it seems that the area first affected is their cognitions. They may initially experience depression as a negative representation of themselves, their family and their life circumstances.

In order to investigate the experience of motherhood, Schwengber and Piccinini (2005) observed that mothers with depression indicators at the end of the first year of the infant's life reported

more dissatisfaction with their infant's development and with the performance of the maternal role. Furthermore, in this study, only the depressed mothers reported difficulty in coping with events considered stressful by them, such as separation from their children due to work, family and marital conflicts, financial problems, and difficulties in the handling of the infant. In the study by Frizzo, Brys, Lopes and Piccinini (2010), depressed mothers also reported more difficulty in different aspects of the marital life, which suggests that depression can affect the family in different ways.

Despite the obvious impact of depression on the mother, the literature has little described its influence on family functioning (Frizzo & Piccinini, 2005; Schwengber & Piccinini, 2004). In the review performed by Frizzo and Piccinini (2005), it was observed that when the mother is depressed, the father can mitigate the negative effects of the maternal depression on the infant. He can provide a positive role model by increasing the care for their children, supporting the mother and contributing to better parenting.

However, sharing the care of children can often be considered inappropriate or insufficient by depressed mothers, either because they consider it an obligation to take care of their infant, or because the way the fathers interact with their children is different from how they would like it to be. Therefore, reports are common of ambivalence regarding the support received from the husband (Frizzo, Prado, Linares, & Piccinini, 2010; Schwengber & Piccinini, 2005), which can cause conflicts between the couple or resentment in the mother.

Maternal depression can therefore be considered as a disorder that affects the family system as a whole. The parental relationships tend to be experienced with more suffering and difficulties in families where the mother is depressed. Accordingly, this study sought to examine parenting in families where the mothers presented or did not present indicators of depression. It was expected to find greater difficulties in the different aspects of parenthood examined in the accounts of families in which the mothers were depressed, compared to the families in which the mothers did not have depression.

Method

Participants

The study included 22 families distributed into two groups, one in which the mothers presented depression indicators (10 participants), and another in which the mothers did not present depression indicators (12 participants), according to the Beck Depression Inventory (BDI) (Beck & Steer, 1993; Cunha, 2001). All mothers of both groups lived with their husbands (although some couples cohabited and others were legally married, in this study it was chosen to talk about 'husbands and wives' to simplify the text), who were the fathers of the babies. In the group of mothers with depression indicators, seven presented indicators of mild intensity and three of moderate intensity. The Socioeconomic Status (SES) of the families, according to criteria based on Hollingshead (1975), adapted for this study by Tudge and Frizzo (2002), was varied. The babies were approximately 12 months of age, 4 girls and 8 boys. Table 1 shows the sociodemographic characteristics of the households.

The sample was selected from among the participants of the *Estudo Longitudinal de Porto Alegre* (ELPA - Longitudinal Study of *Porto Alegre*: From Pregnancy to School) (Piccinini, Lopes, Sperb, & Tudge, 1998), which aimed to investigate both subjective and behavioral aspects of the initial father-mother-infant interactions, such as the impact of initial developmental factors on family interactions, on the social behavior of preschool children and on the transition to elementary education. This study started following 81 pregnant women with their first child, who presented no clinical complications, either in relation to themselves or the infant. The fathers were also invited to participate in the study, if they resided together in a marital situation. The participants represented various family configurations (nuclear, single parent or remarried), had different ages (adults and adolescents), schooling and varied socio-economic levels. Several data collections were

Table 1

Sociodemographic characteristics of the couples in which the wife presented or did not present depression

Family	Maternal depression	BDI Mother	Age	Schooling	Occupation	Infant's gender	Infant's age	SES family
1	Mild	15	M= 23 F= 29	M= Elem. inc F= Elem. com	M= housewife/baker F= hairdresser assistant	Male	12m	1
2	Mild	15	M= 19 F= 27	M= High S F= High S	M= housewife F= salesman	Male	12m	2
3	Mild	15	M= 19 F= 22	M= High S F= High S	M= housewife F= security guard	Male	12m	2
4	Moderate	31	M= 18 F= 19	M= High S F= Elem I	M= housewife F= carpenter	Male	12m	1
5	Mild	12	M= 33 F= 29	M= College I F= College	M= psychologist F= lawyer	Male	12m	5
6	Mild	16	M= 26 F= 40	M= College I F= College	M= student F= court clerk	Female	12m	5
7	Mild	16	M= 17 F= 17	M= High SI F= High SI	M= student F= unemployed	Female	12m	1
8	Mild	12	M= 24 F= 25	M= High SI F= High S	M= waiter F= painter	Female	12m	3
9	Moderate	20	M= 23 F= 38	M= Elem I F= Elem I	M= housewife F= caretaker	Female	12m	1
10	Moderate	25	M= 20 F= 20	M= High S F= High S	M= administrative assistant F= bank worker	Male	12m	3
11	Absent	6	M=26 F= 30	M= Elem I F= Elem I	M= housewife F= caretaker	Male	12m	1
12	Absent	9	M=27 F= 21	M= High S F= Elem	M= general services F= bakery assistant	Male	12m	1
13	Absent	4	M= 23 F= 24	M= High S F= High S	M= receptionist F= printer assistant	Male	12m	2
14	Absent	6	M= 33 F= 33	M= College I F= College I	M= speech therapist F= graphic designer	Female	12m	5
15	Absent	8	M= 18 F= 18	M= Elem I F= Elem I	M= housewife F= builder	Male	12m	1
16	Absent	6	M= 30 F= 35	M= College F= Post grad.	M= programmer F= administrator	Female	12m	5
17	Absent	6	M= 25 F= 32	M= College I F= College I	M= housewife F= public servant	Male	12m	2
18	Absent	11	M= 14 F= 16	M= Elem F= Elem I	M= housewife F= gardener	Male	12m	1
19	Absent	11	M= 27 F= 26	M= College I F= College I	M= car salesman F= insurance broker	Male	12m	4
20	Absent	6	M= 31 F= 30	M= College F= College I	M= businesswoman F= businessman	Male	12m	5
21	Absent	5	M= 28 F= 41	M= High S F= Elem I	M= head of sector F= modeler	Female	12m	3
22	Absent	10	M= 35 F= 41	M= College F= College	M= housewife F= businessman	Female	12m	5

Note: BDI: Beck Depression Inventory; College I: College Incomplete; Elem: Elementary school; Elem I: Elementary School Incomplete; M: Mother; F: Father; High S: High School; High SI: High School Incomplete; Post grad: Postgraduation; SES: Socio Economic Statu.

carried out from pregnancy to when the children were eight years of age (pregnancy, 3rd, 8th, 12th, 18th, 24th, 36th month, and 6th, 7th and 8th year of life of the child). The initial invitation to participate in the study occurred when the mother took part in prenatal care in the public hospitals of *Porto Alegre* (RS) (41%), in the health units of the same city (4%), through an announcement in the media (14%), and by indication (41%). At that time, the initial contact form was completed, 1998, aiming to obtain the sociodemographic data of the participants. The study was approved by the Research Ethics Committee of *Universidade Federal do Rio Grande do Sul* (UFRGS) (Resolution nº 2006596).

Of the 47 ELPA cases evaluated with the BDI at 12 months following the birth of the infant, 26 mothers (34%) presented depression indicators, with 5 (11%) classified as having moderate depression and 11 (23%) mild depression. A total of 31 mothers (66%) did not present depression. For the purposes of this study, all the families in which the mothers presented depression indicators and lived with the husband (the infant's father) and had complete data were initially selected, which allowed the inclusion of ten families. The families were then selected in which the mothers did not present indicators of depression, who had complete data and presented similar sociodemographic characteristics to the group with depression indicators, which allowed the inclusion of twelve families. The Mann-Whitney test did not indicate sociodemographic differences between the two groups regarding the couple's age, education, socioeconomic level, and infant's gender, suggesting similarities in the pairing between the two groups in these variables. This pairing was important in order to achieve the aim of the study. Thus, an attempt was made to control for the effects that other variables, such as socioeconomic status, could have on the parental relationships of the families studied. Accordingly, it was possible to associate the differences found between the groups to the presence or absence of depressive symptoms.

Procedures and Instruments

A contrasting group design was used (C. Nachmias & Nachmias, 1996), aiming to compare eventual differences between the families in which the mothers presented or did not present indicators of depression.

For the purposes of this study only the data collected at 12 months were used. At that moment, the families attended the Institute of Psychology (UFRGS) to conduct the interviews related to this phase. The mother and father responded separately to the Interview about infant development and the experience of motherhood (*Grupo de Pesquisa em Infância, Desenvolvimento e Psicopatologia* [GIDEP], 1999a) and the "Interview about development and the experience of fatherhood" (GIDEP, 1999b), respectively. These interviews were structured and applied in a semi-directed way, and aimed to investigate the maternal and paternal impressions regarding the infant's growth, development, skills, and emotional characteristics, feelings about being a mother/father, impressions about the husband as father and the wife as mother, the support father network in relation to infant care, and the occurrence of stressful events. Next, the couple jointly responded to a joint Interview about an infant of twelve months (GIDEP, 2000), in order to investigate how the marital relationship was at that moment, as well as their routine. The Beck Depression Inventory (Beck & Steer, 1993; Cunha, 2001) was completed only by the mother.

Data analysis

The interviews were analyzed using qualitative content analysis (Bardin, 1977; Laville & Dionne, 1999), aiming to identify the maternal and paternal reports associated with the theme of sharing children's care (Waldemar, 1998). After careful reading of all the interviews and the identification of all the reports, these were classified into three categories: task division related to infant care, financial concerns and disagreements, and conflicts regarding infant care. Secondly, it was sought to identify the reports that were associated to the mothers with and without indicators of

maternal depression, derived from both the interviews with the mothers and those with the fathers. The analyses were performed independently by two of the authors of this article, with any differences reviewed and discussed until a consensus was reached. After classifying the reports into the categories, the discussion of the results was performed, based on the literature.

Results and Discussion

In the results, each of the three analysis categories are illustrated with the reports of the mothers and fathers, highlighting any differences related to the mothers who did or did not present depression. Although the correct term is mothers with indicators of depression, to make the text clearer, we chose to use the term depressed mothers in the vignettes. Also in the vignettes, the letters "cd" refer to families with mothers with depression indicators and "sd" to families with mothers without depression indicators. The letter "M" refers to the mother's vignettes and the "F" to the fathers'.

Tasks division related to infant care

This category referred to the father and mother sharing infant care or not. In the families with depressed mothers (cd: M1/M3/M5/M6/M7/M8/M9/M10/F1/F2/F3/F4/F5/F6/F7/F8/F9/F10) the mothers reported that the fathers helped; however, they needed to ask for their help because they seemed to be less spontaneous than the fathers of the families with non-depressed mothers: "I need to ask. Sometimes he goes and does. But most of the time I have to ask" (cd: M10). Some fathers of the families with depressed mothers thought that they helped a lot playing with the infant and, in these cases, there seemed to be a more traditional division task. "I play with him at times that his mother cannot. Those specific diaper things, I don't do" (cd: F5). Especially when the mother did not work outside the home (cd: M2/6), the father's task

was to work and that of the woman is task was to care for the infant: "Because if I have to take care of the store, and come home and take care of him [son]... It's no good. So, I take care of the store, I take care of the basement, and she takes care of the house" (cd: F2).

In general, the husbands of depressed mothers said they helped whenever their wives asked (cd: F1/F2/F3/F4/F8/F9) "So whatever she needs I'm always there. Sometimes I'll stay with her so that she [wife] can go out... I participate a lot" (cd: F8); some said they liked caring for the child (cd: F2/F5/F9/F10): "I change the baby's diaper, it's no problem. I like it too. It's no problem for me, change the diaper, bathe, no problem" (cd: F3) and they often don't do more due to work (cd: F6/F7): "If I could, if I did not have to work, I'd be with her [infant], take care of her, no problem at all, because I took care of her up to about four months, when I was not working" (cd: F7). In some of the families with depressed mothers, the husbands reported that they also helped with the housework (cd: F1/F9/F10): "I participate in everything, you know, I help. Even in cleaning the house, we do it together" (cd: F10).

As for the non-depressed mothers, they reported that their husbands were very participant and involved in child care: "He does it together with me, sometimes on the weekend I'm tired, I just want to stay laying about at home, then he takes her to the park on his own, he goes out for a walk, to do things, he is not lazy" (sd: M22). The impression was that these non-depressed mothers felt helped by their husbands, however, still considered that the task of caring for the infant was mostly theirs: "I go in the morning, get him ready [son], leave him semi-ready, then he [husband] finishes it, I leave him with the shirt that he will use, I let him sleep, is to make his father's life easier" (sd: M17). The impression was that there was a more natural division of tasks between the father and non-depressed mother and, in general, there were no reports emphasizing the need to ask for help (sd: M12/M13/M14/M15/M17/M19/M20/M21/M22): "Sometimes, I see that he doesn't realize that

I need help, because when he realizes he jumps” (sd: M17).

The fathers of families without depression reported that they help caring for the children (sd: F12/F14/F15/F16/F17/F19/F20/F21/F22): *“Then I picked her up, I give her the milk, sometimes I give her dinner. I change the diapers. Sometimes I put her in the car seat and go out for a drive with her”* sd: F21. One father reported that he just did not like to take care of feeding the child: *“What I find tiring is giving food, so when I can, I run away, I think it is tiring”* (sd: F14). Some fathers said they spend a long time with the babies due to mothers’ work, who arrived at home later (sd: F12/F15): *“I seed him, bathe him, and I’m always joking with him, when she [wife] arrives she cares for him, sometimes I do some housework”* (sd: F15).

In general, in these families where the mother did not have depression, it seemed that the father showed more willingness to be involved with the infant (sd: F14/F15/F16/F17/F19/F20/F21) as in the following example: *“I think she likes it, because I do everything, I help her a lot, so, from what she tells me, I’m very participatant and help a lot. It’s because I’m not opposed to anything, you know, I do everything that has to be done”* (sd: F20). However, some fathers perceived that they could help more in infant care (sd: F11/F13/F16): *I have not taken the initiative to do these things”* (sd: F16).

In the groups of families with depressed and non-depressed mothers, some families reported no division task related to infant care. Among the depressed mothers (M1/M2/M4/M5/M6/M7), in only one case there appeared to be greater acceptance of this, because the mother did not work outside the home: *“I assume all the tasks, because he [father] goes out in the morning and comes back at night. So everything that had to be done has already been done for him during the day...”* (cd: M2). The other depressed mothers reported various complaints (cd: M4/M5/M6) concerning the absence of a task division, including explicit refusals by their husbands to share child care: *“So, I have to learn someday. “Oh, I’m not going to change his diaper’. Then I tell him, “I won’t change him either’. Then he takes him... [Laughs] and gives him to my sister to change. Even standing next to you, he does not*

try to learn” (cd: M3). In some cases, there was no conflict regarding the father’s non-involvement and his unwillingness to be involved (cd: M1/M2/M4/M7) *“No, when I’m at his house, sometimes I ask him; before I even asked him to change a diaper, now I don’t even ask, because he will say no”* (cd: M4).

In the group of non-depressed mothers (sd: M11/M13/M16/M17/F11/F13/F15/F16/F20), there seemed to be greater acceptance from the mothers regarding the absence of a task division with her husband: *“He still has not bathed him, maybe when he [son] is bigger, right. Because he prefers that I do it, because I’ve already got my way. But he’s present when he can be”* (sd: M13); except in two cases (sd: M20/F16): *“I do not even take the initiative most of the time, she does it, it is her that does almost everything”* (sd: F16). Some fathers of this group (sd: F11/F16) seemed to not want to take care of the infant, unless it was really inevitable: *“I wait for her to demand, then I do it”* (sd: F16). One father of this group even reported that it was he who took care of the infant most of the time: *“Now the business is just mine, I take care of her”* (sd: F15).

Based on the above reports, it can be noticed that in both the families with depressed mothers as well as in those without depression, reference was made to the absence of a task division related to infant care, both by fathers and mothers. However, what seemed to differentiate the two groups was a higher incidence of reports of dissatisfaction by the depressed mothers regarding this theme, unlike the non-depressed mothers, who did not report this. In the families without depression, the demands and exchanges seemed to flow more easily and spontaneously, even when there was no division of the tasks, so that there were no difficulties reported. This can be associated to the fact that, according to Frankel and Harmon (1996), depressed mothers may experience depression as a negative representation of themselves, of their family and of their life circumstances, which may also reflect in a negative evaluation of the support received by their husbands.

Based on the reports of both groups of families, the impression that is given is that, in families with depressed mothers, women had a more negative perception of support (Mayor, 2004; Schwengber & Piccinini, 2005), or they had difficulty asking for help, maybe because they assume that infant care was their duty only (Linares & Campo, 2000), or even that this support was really insufficient, since several fathers reported that they only helped if requested.

It could be thought that the absence of a task division, in both groups, suggests a lack of definition of the role of the father in caring for the home and the child, which had become a particular difficulty in the families with depressed mothers. Although the majority of interventions for postpartum depression focus on depressed mother, several studies indicate the importance of the father in this context, supporting the depressed mother, both instrumentally or emotionally, being someone who may help alleviate the depressive symptoms (Fletcher, 2009; Frizzo et al., 2010; Silva, 2007). Furthermore, considering the parental couple, for a couple to be considered healthy, clarity of rules, roles and messages are necessary (Walsh, 2002). Good communication regarding each one's role in the housework and in infant care can be very important in order to enable the partners to refine and make explicit their ideas and expectations in relation to one another, to their marriage and to themselves and, in the case of this study, with respect to sharing infant care.

This subcategory appeared especially in reports fathers' (cd: F2/F4/F8/F10). Although there were no significant differences in socioeconomic status between the two groups, in the families with depressed mothers (cd: F2/F4/F8/F10), this category appeared with more frequency and intensity, and was related to reports of specific difficulties: "We have just gone through a very difficult economic time. Now my business is not making much profit. And I think that it is the most critical time now, more because of the finances" (cd: F8). Only one depressed mother made a report included in this category, when she referred that her husband became more concerned about saving money, after

infant birth: "[before] He did not think about saving money, did not think about economizing, about being someone" (cd: M2).

In the families without depression (sd: F13/F19), the financial issue appeared only in the paternal reports and was associated with fathers' desire to be able to give more things to the child: "Difficulties... in fact, it is only financial difficulties to be able to provide all I want for him" (sd: F19).

The difficulty in coping with financial problems has been intensively associated with the occurrence of maternal depression in the literature (Cramer, 1993; O'Hara, 1997; Robila & Krishnakumar, 2005). When comparing mothers' reports with and without depression, Schwengber and Piccinini (2005) found that only the depressed mothers reported it being difficult to deal with financial difficulties, similar to the results of the present study.

Disagreements and conflicts regarding infant care

Generally, there was a greater incidence of reports of conflicts in the families with depressed mothers than in those without depression. Mothers' reports in both groups (cd: M1/M2/M3/M4/M5/M6/M8/M9/M10; sd: M11/M13/M14/M15/M16/M17/M19/M20) were related to three common themes of divergence regarding infant care: infant's sleeping pattern: "Sometimes [father's name] thinks she's not sleepy, she does not want to sleep, I want to put a limit for her, yes, because that is the time to sleep, that's it. Some things like that, but otherwise, no" (sd: M14); feeding the infant: "At lunch my husband does not like me to let her make a mess, when I give the bowl to her" (cd: M9); and infant's discipline: "If he [infant] is doing something wrong, then I think it's wrong, I'll complain. I will not let him do it... but the father does not. His father lets him" (sd: M11). Although there were no divergences of themes between the mothers of the two groups, there was a higher incidence of maternal reports in the families of depressed mothers. It is possible that the differences in infant care are common to all the families because the mothers and fathers come from

different family models. However, interventions focused on this aspect can bring significant improvement in the coparental relationship, as reported in a case of Parent-Infant Psychotherapy (Frizzo, 2008) in which the mother was asked to show her husband how he should change the diaper of the infant. In this case, the father not only showed that he knew how to do this activity, but that he could cooperate more in infant care, because he started to change the diapers of the child when he was at home. Thus, there was a decrease in fights, since the mother was relieved to see that the father and child interacted very well in those moments.

When talking about specific aspects of the mother-infant and parent-infant interaction characteristics, Brazelton and Cramer (1992) highlighted the importance of the infant having contact with different caregivers. The fact that the infant responds differently to the father and to the mother causes the parents to feel important, in addition to helping to differentiate their own selves. For Margolin, Godis, and John (2001), the differences related to the care of the children become problematic when they become conflicts between the parents, especially when they start to disrespect each other's values and rules in raising the child. In these cases, interventions aimed at decreasing or clarifying the differences can be very important for the relationship of the parents (Frizzo, Kreutz, Schmidt, Piccinini, & Bosa, 2005).

The fathers of the families in which the mothers presented depression (cd: F2/F4/F5/F6/F7/F8/F9/F10) highlighted the excessive autonomy given by the wives to the babies *"And I always tell her it can't be like that. He [the infant] has to go bit by bit"* (cd: F6) and complained of the lack of responsibility of the wife in child care *"there was even a phase that she did not like to make our daughter sleep, so she asked me to do. I fought a bit with her, because she also had to help too, it is not just me who has to do the things... or in the middle of the night.. she cried and then I had to wake up because she did not like to get up. Then I fought with her"* (cd: F8), and of the mother's lack of patience when dealing with the child *"Sometimes*

we have a few squabbles, but nothing serious. Sometimes, it is difficult... she runs out of patience very easily." (cd: F10). The fathers of the families in which the mothers presented depression (sd: F12/F14/F16/F19/F20/F22) highlighted mothers' excessive pampering and overprotection of the mother with the infant as a reason for conflict: *"I think she pampers him [infant] too much, right, she does what he wants, and I try to cut that out [pampering]"* (sd: F20).

When contrasting the reports of the families with and without a depressed mother, it can be seen that in the families with depression, the conflicts reported by the fathers were related to a lack of care and attention for the babies on behalf of the mothers, unlike the families in which the mother presented no depression, in which fathers' criticism was related to the mothers' excesses of pampering and care for the infant. One possible explanation is that one of the ways that depression can affect the mother-infant relationship is by decreasing the mother's field of attention and problem-solving skills (Teti & Gelfand, 1991), which together with their inhibition and social withdrawal (Brazelton & Cramer, 1992), constitute major obstacles to constructing a healthy mother-infant relationship. Another way that depression affects the mother-infant relationship is through an increase in the mothers' irritability, making it difficult to harmonize and interact with the infant (Brockington, 2004; Frizzo, 2008), as reported by the husbands of the mothers with depression.

In the group of families with depressed mothers, there was also the report of one mother about her husband's lack of involvement with the child, *"He gets the child clean, cute. Then at the time he is needed he doesn't participate, you know?"* (cd: M1). Furthermore, when comparing the reports of the mothers and fathers in the families with a depressed mother, there was agreement regarding the low participation and involvement of the father, reported by both parents: *"If I help, she doesn't like it, you know. She would like me to participate more"* (cd: F2).

This result is quite interesting because the literature (Fritsch et al., 2005; Mayor, 2004; Schwengber & Piccinini, 2005) suggests that when the mother is depressed, she tends to report greater dissatisfaction with the support received. However, according to the results of this study, it is possible that this lack of support is real and not just the mother's negative impression, since the husbands reported that they really could help more. Another possibility would be that perhaps fathers helped their wives, however, this was not understood as being enough by either of them, as it is common for husbands of depressed wives to report anxiety and helplessness due to not knowing how to deal with the depressed wife and with the consequences of the depression in family relationships (Frankel & Harmon, 1996; Fritsch et al., 2005; Frizzo, 2008; Frizzo et al., 2010). Thus, the impact of depression can be perceived on the family as a whole, affecting the depressive mothers' feelings and, also the relationship with her husband and her infant.

As final considerations, the present study aimed to investigate the differences in parenting in families in which the mothers did or did not present indicators of depression when the infant was at the end of the first year of life. The results supported the initial expectation that the presence of depression in the mother can lead to difficulties in her relationships with both the husband and the infant. A contribution of the present study was to contrast fathers' reports in this context, since most of the literature on the subject has only the mothers as participants. Furthermore, specifically regarding the issue of task division, with the inclusion of the father's statements, it was possible to question if the mothers had the support of the husbands or whether the dissatisfaction might also be characteristic of the depressive disorders. It is important to highlight that the father's participation in situations of maternal depression may be of great help especially in interventions aimed at treating the depression. If the father's presence and support does not prevent the onset of the wife's depressive symptoms, it can still help in the identification and remission of these symptoms (Frizzo, 2008; Silva, 2007).

In some cases in which the mothers were depressed, it was observed that their husbands perceived them as particularly more irritated or with more difficulty in caring for the infant, even though, there was no previous diagnosis of depression in any of the cases. The literature suggests that these cannot be isolated cases, because depressive symptoms may often be confused with the natural postpartum deterioration and also throughout the first year of the infant's life, due to infant care and the sleepless nights, as well as the accumulation of household tasks (Frizzo, 2008; Nonacs & Cohen, 2005). Therefore, it is common for the mother and the people who surround her to not always recognize that her symptoms may be indicative of depression.

According to Nonacs and Cohen (2005), only one third of the women with *postpartum* disorders seek treatment, and when they do, they typically report that the depressive symptoms had started many months before. Furthermore, according to these authors, women with *postpartum* depression have a 50% chance of recurrence. Accordingly, interventions that provide guidance on the issue of postpartum depression, both in the prenatal and postpartum periods, are necessary in order to avoid the mothers undergoing unnecessary suffering due to their delay in seeking specialized care. In addition, as depression can affect the relationship with the infant, it is essential to seek help before it negatively affects the development of the mother-infant relationship.

It is important to note that the mothers of this study showed indicators of depression only through the BDI, not being characterized as a clinical depression sample. The BDI was used as a screening instrument in the longitudinal study that the participants took part in, investigating various aspects of parenting, including indicators of depression. To be certain of the diagnosis of depression, mothers need to be more thoroughly evaluated, using more instruments and clinical interviews. Further studies could extend the results described in this paper by investigating clinical samples of depressed mothers, possibly with more

obvious and acute depressive symptoms, with greater impact on the mother's cognitions and relationships.

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