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# Will Mothers Discuss Parenting Stress and Depressive Symptoms With Their Child's Pediatrician?

Amy M. Heneghan, MD\*; MaryBeth Mercer, MPH‡; and Nancy L. DeLeone, MA‡

**ABSTRACT.** *Background.* Parenting stress and maternal depressive symptoms are ubiquitous and have negative consequences for children. Pediatricians may be an underused resource to mothers regarding these issues.

*Objective.* To explore maternal beliefs and perceptions about discussing the stress of parenting and depressive symptoms with their child's pediatrician.

*Design/Methods.* Mothers were recruited from 5 community-based pediatric practices and 1 hospital-based practice to ensure a diverse sample. An experienced, trained facilitator conducted focus groups by using open-ended questions and administered a standard questionnaire. Audiotapes and transcripts of the groups were reviewed for major themes by 3 independent researchers using grounded theory and immersion/crystallization technique.

*Results.* Seven focus groups ( $N = 44$ ) were convened. Participants were 70% black and 30% white with a mean age of 27 years; 61% were single; 50% were educated beyond high school; and 43% received public assistance as their main source of income. The mean score on the Psychiatric Symptom Index was 26.3 (high  $\geq 20$ ). Within 2 overarching domains (maternal and interaction between mother and pediatrician), several themes emerged. Within the maternal domain, dominant themes included 1) emotional health: all respondents indicated that a mother's emotional health greatly affects her child's well being; 2) self-efficacy: mothers believed in the importance of accepting responsibility for monitoring their own well being and that of their child; and 3) support systems: all mothers expressed the need to share parenting experiences, stressors, and depressive symptoms with someone (most preferred to speak with family or friends rather than with their child's pediatrician). Within the interaction domain, 2 themes emerged: 1) communication: open communication with a pediatrician who listens well was perceived by mothers in all groups as very important, and 2) trust: mothers trust pediatricians with their child's health, but many were hesitant to discuss their own stress or depressive symptoms. Mothers in all socioeconomic groups expressed fear of judgment and possible referral to child protection if they talked about such issues. Both of these were mediated by the presence of an ongoing relationship between the

pediatrician and mother. Mothers were more likely to discuss their own emotional health if they felt their child's pediatrician "knew them well."

*Conclusions.* Mothers are aware that their own emotional health has consequences for their children. Although many mothers experienced lacks in their social support systems, many are reluctant to discuss parenting stress and depressive symptoms with their child's pediatrician because of mistrust and fear of judgment. Mothers are, however, generally receptive to the idea of open communication with their pediatricians and are interested in receiving supportive written communication about parenting stress and depressive symptoms from pediatricians. These qualitative data are valuable in developing an intervention to help pediatricians assist mothers at risk. *Pediatrics* 2004;113:460-467; *depressive symptoms, maternal, focus groups, pediatric providers, parenting stress, primary care.*

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ABBREVIATION. PSI, Psychiatric Symptom Index.

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Depressive symptoms in mothers are common<sup>1-6</sup> and have serious negative consequences for children,<sup>7-12</sup> yet mothers with depressive symptoms may not be recognized and treated by their own primary care providers.<sup>13-17</sup> Because depression and depressive symptoms in mothers with young children are prevalent and associated with adverse outcomes in children, pediatricians and other pediatric health care providers have been urged to screen for maternal mental health problems and family stresses.<sup>3,18</sup>

Pediatric primary care visits may provide a good opportunity for pediatricians to identify mothers with depressive symptoms. Although some mothers may lack primary care providers of their own, mothers interact with pediatricians on a regular basis in bringing their young children for pediatric health care. Pediatric providers who develop an ongoing relationship with mothers often discuss various stresses experienced in parenting children. As such, they are poised to "address family problems" in the context of health supervision, as recommended by both the American Academy of Pediatrics<sup>19,20</sup> and *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*.<sup>21</sup> Screening for maternal and family problems is a promising avenue by which pediatric primary care providers can increase their effectiveness at dealing with and preventing a variety of childhood problems.<sup>18,22-25</sup>

Some studies, however, suggest that pediatricians may not be effective at identifying mothers with

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depressive symptoms.<sup>26,27</sup> A better understanding, therefore, of both mothers' and pediatricians' perspectives that may impede or enhance discussion of maternal depressive symptoms is essential in developing strategies to improve recognition and management of maternal depressive symptoms within pediatric health care settings. If such interventions are to be incorporated into the existing paradigm of primary care for children, it first must be understood how mothers feel about discussing the stresses of parenting and their own mental health concerns with their child's pediatrician. Little is known about the perceptions mothers have regarding the role pediatricians can and should play in addressing maternal mental health concerns. Therefore, this study used a targeted set of questions to ask mothers of young children about their experiences as mothers and their beliefs and attitudes related to discussing the stress of parenting and depressive symptoms with their child's pediatrician.

## METHODS

Focus groups were conducted with mothers of young children to explore maternal beliefs and attitudes. This method is useful to examine perceptions of a problem that may not be adequately addressed in health care practice.<sup>28</sup> A focus group is a "carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment."<sup>29</sup> Focus-group methodology was ideal for this research for several reasons. First, focus groups enable researchers to gather exploratory data on relatively new topics of interest.<sup>30–32</sup> Second, the interactive nature of the focus-group format enables participants to be spontaneous and discuss preidentified topics in depth, thus providing valuable experiential data.<sup>33</sup> Other investigators<sup>34–36</sup> point out that focus groups are ideal for discussing sensitive topics such as maternal depression, because members may encourage each other to share similar experiences. Fundamentally, focus groups are used as a way of listening to people and learning from them.<sup>31</sup> Finally, data from focus groups can be used to design and implement tailored interventions.<sup>29,30,37</sup>

### Sample

Mothers bringing their child for routine pediatric care were recruited from 5 community-based practices and 1 hospital-based practice to participate in a focus-group discussion for mothers of young children. Purposeful sampling of mothers was performed by posting flyers in each pediatric waiting room that announced a research project to explore feelings of mothers with young children. No mention of depressive symptoms was made in the flyer. Although it is possible that selection bias occurred, it was not exacerbated by the text used to recruit mothers to participate. The flyers described the content of the discussions and instructed potential participants to call the study director for enrollment. In addition to the posted announcement, mothers were recruited in person from the hospital-based pediatric practice. This was done to ensure adequate representation of nonwhite, inner-city mothers in the study.

Mothers were screened by telephone to ascertain age, educational level, number of children, and income sources. These data were collected to match participants within each focus group to optimize group cohesiveness and compatibility. Focus groups were conducted at a community-based facility during afternoon and evening hours to accommodate participants. Written, informed consent was obtained at the beginning of each focus group according to the guidelines of our institutional review board. Participants were compensated for their time.

### Data Collection

Focus groups were conducted by a trained facilitator with extensive experience in moderating focus groups and conducting in-depth interviews. The questions asked in each group were standardized using a guidebook (Table 1) that was developed a

priori and adapted slightly after the first focus group to include the "ice breaker": "What do you enjoy most about being a mother?" This strategy of starting with a nonthreatening, general question and progressing to more-specific areas of inquiry has been recommended as a way to encourage trust among group members.<sup>38</sup> Questions were developed to query 2 overarching domains: those inherently related to the mother and her personal beliefs, perceptions, and coping mechanisms and those that capture the pediatrician-mother interaction as it relates to discussion of a mother's well being. Each group was audiotaped and subsequently transcribed verbatim with little to no data loss. Transcriptions were reviewed for accuracy and clarity by the focus-group facilitator.

At the conclusion of each focus group, mothers were asked to complete an exit survey that included demographic information and a measure of depressive symptoms, the Psychiatric Symptom Index (PSI).<sup>39</sup> The PSI is a 29-item scale with excellent internal consistency, reliability, and concurrent validity<sup>39</sup> that contains items that measure the frequency of symptoms experienced during the past 2 weeks from "never" to "very often." Examples include how often you "have had trouble concentrating," "noticed your hands trembling," "felt fearful or afraid," or "felt downhearted or blue?" PSI items are scored by using a 4-point scale (0–3) with the total score and subscales (depression, anxiety, anger, and cognitive disturbance) calculated as a percentage of the total possible score. A total score of  $\geq 20$  represents a "high" level of symptoms and suggests a high likelihood that the respondent had significant distress and depressive symptoms. Although not diagnostic of depression, a PSI score of  $\geq 20$  reflects a mother at risk.<sup>39</sup>

### Data Analysis

Analysis was overseen by a researcher experienced in coding and analyzing qualitative data using immersion/crystallization techniques.<sup>40–42</sup> The immersion aspect of this technique was conducted by reviewing the transcript for each focus group and listening to the audiotape to enhance the written word by the nuance and tone conveyed on the audiotapes. For each focus group, facilitator notes were also reviewed. These notes had been made contemporaneously during each focus-group session by the principal investigator and captured affective responses such as head nodding and facial expressions not picked up by audiotape. Transcriptions were coded by beginning with the first question and continuing question by question until all responses to each question (including noted nonverbal responses) were written down. Within the 2 predetermined domains (ie, maternal and pediatrician-mother interaction), consistent categories began to emerge. Three themes were identified within the maternal domain, and 2 were identified within the interaction domain. The coding of responses was performed by the investigators in an iterative process with review and discussion to achieve agreement between coders. This rigor is part of the process of crystallization of data.<sup>43</sup>

## RESULTS

In total, 7 focus groups ( $N = 44$ ) were convened. Overall, participants were 70% black and 30% white with a mean age of 27 years; 61% were single; and 50% were educated beyond high school. Slightly less than half (43%) received public assistance. The mean score on the PSI was 26.3 (high  $\geq 20$ ). The mean number of children was 2 with mean age of 6 years, 1 month. Demographics for individual groups are shown in Table 2.

Within the 2 domains, consistent themes emerged across all questions and in all groups. Themes within the maternal domain included emotional health, self-efficacy, and support systems. Themes within the interaction domain included trust and communication (Table 3).

### Domain I: Maternal

Responses in this domain reflected mothers' inherent belief systems, maternal self-perceptions, and

**TABLE 1.** Focus Group QuestionsMaternal

- What do you like best about being a mother?
- How do you think your own emotional health affects your child?
- Do you ever feel sad or blue? Depressed? Angry? Anxious or worried? Who do you talk to about such feelings?

Pediatrician/Mother Interaction

- What qualities do you look for in a pediatrician?
- What do you usually talk about with your child's doctor?
- What would you like to talk about with your child's doctor?
- Does your pediatrician ask you how you are doing during your child's visit? Do you spend time talking about your health and well-being?
- Do you ever discuss the stress of parenting with your pediatrician? Who raises the issue? Can you give an example of such a discussion?
- Would you feel comfortable talking to your child's pediatrician about such feelings? Why or why not?
- If your pediatrician recommended you to a counselor or other doctor to take care of yourself, how would that make you feel (or how would you react)?
- Is there anything else your pediatrician might do to help you?
- Is there anything else that you would like to discuss?

copied styles and fell into 3 main themes: emotional health, self-efficacy, and support systems.

*Emotional Health*

Mothers in all groups agreed that a mother's emotional health greatly affects her child's well being. All mothers had an appreciation of the potential impact their own emotional state has on their children. They used visual symbols of mirrors, circles, and sponges to describe the bond that exist between parent and child. For example, 1 mother described her feelings as "circular," ie, her emotional health and her child's are a continuum. Mothers used phrases such as "if mama ain't happy, nobody's happy" to convey that their emotional state is reflected by their children. Mothers believed that children pick up cues and absorb the emotional energy of their parents: "they know." One mother stated: "How you cope is how they cope." Others described precisely what occurs when their affect is transferred to their child. One mother stated: "My anger triggers anger, frustration, and anxiety." Another stated: "My tears trigger concern and sympathy." In sum, mothers in all

groups believed that they set the mood for their households.

Participants saw motherhood as giving them opportunities to be fulfilled and creative, to receive love and support from offspring, and to experience delight, warmth, and comfort. On the other hand, mothers were forthright in sharing their feelings of sadness, anger, and especially anxiety. Parenting was perceived as fulfilling but stressful. Words often used by mothers were "consuming," "overwhelming," "stressed out," and "big responsibility." The emotional toll of parenting was articulated by mothers in all groups. First-time mothers perceived that their lives had "totally changed." "I need a break" was the comment made most often, repeated by mothers in all groups, but especially by mothers who had sole responsibility for caring for their children.

*Self-Efficacy*

Mothers across all groups exhibited personal resourcefulness and self-efficacy. Motherhood appeared to draw out these qualities in many respondents. Mothers believed that much of their strength

**TABLE 2.** Maternal Demographics by Group

	Group						
	1	2	3	4	5	6	7
N	4	2	8	5	4	10	11
Race							
Black	3	2	2	2	1	10	11
White	1	0	6	3	3	0	0
Single	3	2	1	1	0	9	11
Married	1	0	7	4	4	1	0
Education							
<High school	0	0	0	0	0	0	1
High school degree	1	1	0	2	0	7	9
>High school	3	1	8	3	4	3	1
Mean age	20.6 y	25.5 y	31.9 y	32.4 y	34.1 y	23.9 y	23.9 y
Mean age of children	30 mos	10.5 mos	25 mos	9.5 y	15 mos	9.4 y	8.5 y
Mean total PSI score	28.74	7.47	24.13	18.39	29.02	23.9	33.9

**TABLE 3.** Crystallization of Maternal Data: Capturing the Essence

Participant Data	Themes	Domains
If mama ain't happy, nobody's happy. They know. I need a break.	Emotional health	MATERNAL
If my child's OK, I can take care of everything else. Need to build my self-esteem.	Self-efficacy	
I was dying to meet other mothers. Fathers want power, but no responsibility.	Support systems	
May think I'm unable to take care of my kids. Need to choose words carefully. Ask without prying. Just listen.	Trust	
	Communication	PEDIATRICIAN/MOTHER INTERACTION

and sense of self arise from motherhood. One mother said "If my child is okay, I can take care of everything else." Mothers placed a great premium on their sense of control and "choice" as well as "building self-esteem." As stated by a mother in group 1: "You have to influence your environment and not let your environment influence you." There was general agreement across all groups that methods such as journal writing, prayer, and talking to someone close were effective stress reducers and effective ways to enhance self-efficacy.

*Support Systems*

Within the maternal domain, the theme of support, or lack thereof, was well developed, consistent across all groups, and a frequent response to each question. Mothers were keenly aware of their need to feel supported in their roles as mothers. More importantly, perceived lack of support was a frequent stressor to mothers and quite undesirable, especially when it was the child's father that was unsupportive. Mothers in all groups wanted and needed to share parenting experiences and the stresses of parenting. They believed sharing was helpful to process their feelings (especially ambivalent ones) and to gain information and advice from others to help them become better parents.

Pediatricians were not mentioned as a key support for mothers. Instead, mothers turned to their family, especially their mothers, their friends, and even their children for their encouragement, advice, and emotional support. Overwhelmingly, mothers reported that other mothers are a strong source of support. "Feeling blue is not as bad if you have another mother you can call on." Mothers felt that being able to talk about their child and their feelings about being a parent was most helpful when they could do it with other mothers.

An unexpected development within the groups was that the atmosphere of the focus groups quickly became therapeutic for participants in that they felt a rapport with fellow participants and gained a sense that others felt the same way. Despite the fact that the aims of the focus group were clearly presented to mothers in recruitment and again at the time the focus group convened, every group had 1 member

ask when the group could meet again, as if it were a support group. In fact, group 3 left the focus group en masse to reconvene informally and continue their discussion. Mothers in every group exchanged information and phone numbers, pleased that they had connected with other mothers. It was summed up best by 1 mother in group 4: "I was dying to meet other mothers."

Lack of support, particularly from the child's father, was very difficult for mothers. This was raised in all groups but predominated as a topic in groups 2, 6, and 7, which were comprised of single mothers. Fathers were described as "unsupportive, neglectful, and unreliable." Fathers were perceived as not wanting to spend time with their children and "wanting power but assuming no responsibility." Lack of paternal involvement was pointed out in all groups. Although more distressing among single mothers, it was a perception even among married mothers. Married mothers stated: "My husband expects me to know exactly what I am doing" and "everything falls on me."

**Domain II: Pediatrician-Mother Interaction**

Within this domain, 2 themes resonated within our focus groups: trust and communication. Both of these themes were significantly modified by a mother's perception of the continuity of her relationship with her child's doctor. Themes of trust and communication were raised in all groups by virtually all participants. Explication of these dominant themes follows.

*Trust*

Mothers in our sample trust pediatricians with their child's health. They feel comfortable and confident that the pediatrician will identify and treat conditions that affect their children. Certain issues mothers discuss with their child's pediatrician during a health care visit were consistent across all groups, including how their child is eating, developing, and growing. Despite the fact that the pediatrician often asks a mother how she is doing at her child's visits, many mothers reported that the pediatrician's role is to focus on the health and well being of the child, not the mother. Some mothers stated that the pediatri-

cian's being a parent is important to building trust, because pediatricians who have children of their own are better able to view the stresses of child rearing from a similar perspective. Also, mothers had trust in pediatricians who valued their opinions, assumed they knew right from wrong, and were willing to spend time during a health care visit listening to their concerns.

The most salient and consistent finding was mothers' fear of judgment. Mothers drew a line at discussing issues beyond what is child centered and expressed feelings of discomfort and distrust because of such fear. When asked "do you ever discuss the stress of parenting with your pediatrician?" many mothers had reservations about doing so. For example, 1 participant stated: "Pediatricians are trained to take care of kids, not us." They reported hesitancy to volunteer information because they would not want the pediatrician to "think I'm unable to take care of my kids." Because a lot of their identity is defined through motherhood, admitting any difficulties to pediatricians would be akin to admitting failure. Reluctance to volunteer such information was pervasive in all groups. One mother stated that she needed to "read her doctor's motive" to decide whether she would engage in discussion regarding her feelings. The need to "choose words carefully" and to gauge the pediatrician's response was a recurrent comment. Mothers were very concerned about how they presented themselves to their pediatrician, making statements such as "I hold things back" and "I won't be forthcoming." Most mothers said that, although they would not raise the issues of parenting stress, they would answer questions if asked.

Probing further, strains of a more concrete fear began to emerge. Mothers repeatedly described a fear that their pediatrician would interpret their request for help as a threat to their child's safety and, as a consequence, would refer them to child protective services. Mothers in lower socioeconomic status groups were particularly fearful of social work intervention, because they believed that a primary function of medical social workers is to remove the child from the home rather than to act as a resource for help. Although this concern was raised more strongly in the lower socioeconomic status groups, mothers in every group raised this fear of referral to child protective services. This is a significant finding and has important implications regarding reluctance of stressed mothers to speak out to professionals whom they fear may deem them as unfit mothers.

#### Communication

Open communication with a pediatrician who listens well was perceived as very important by all mothers. Mothers listed qualities that represented good communication styles that facilitated discussion of parenting stress and depressive symptoms. Likewise, they listed several communication "don'ts" that made them less willing to share their feelings with the pediatrician (Table 4). Mothers were all in agreement that pediatricians needed to be open to mothers' concerns and ask questions in the right

**TABLE 4.** Mothers' Suggestions For Communication

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Do . . .
"respect my opinions."
"take time to listen."
"anticipate my concerns."
"talk to my child/care about my child."
"ask me the right questions."
"ask; I would answer."
Don't . . .
"judge me."
"cut me short."
"talk down to me."

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way. Inquiries that were felt to be intrusive or judgmental were poorly received. Mothers talked at length about "pediatricians who care." There were many who felt strongly that it was the pediatrician who set the tone when discussing maternal issues. Overall, mothers agreed that they were more likely to discuss the stresses of parenting if they felt their pediatrician considered the whole family environment. One mother stated: "The pediatrician has a wonderful opportunity to treat the entire family for the benefit of the child." Mothers opened up more with pediatricians who "ask without prying" and who can give "targeted advice without being pushy or intrusive." Most of all, mothers wanted a pediatrician that will "just listen." It is a paradox, however, that although some mothers want pediatricians to ask and will not offer any information unless asked, the overwhelming majority of mothers wanted pediatricians to be a sounding board rather than to intervene with them directly. One mother stated: "If a pediatrician initiates it [discussion], then I'll know she cares."

#### *Continuity of the Pediatrician-Mother Relationship: Mediating Effects*

Many of the barriers to trust and open communication were alleviated when mothers had a continuing relationship with their child's pediatrician. Mothers appreciated when their pediatrician remembers her and her infant and preferred to "deal with one regular doctor." Mothers expressed that continuity of care was inherently tied to competence; mothers felt that the pediatrician was capable if there existed an ongoing relationship between her child and the pediatrician. Throughout all the focus groups, mothers stated that they would be more receptive to their pediatrician recommending a counselor if they had an ongoing relationship with the pediatrician. Then it would "give the pediatrician the right and the opportunity to ask those questions." If there is continuity of care, mothers believed pediatricians would be in a position to "notice something" amiss and then initiate discussion, ie, "let's talk about it." The interaction between trust and continuity of care is summarized best by 1 participant who stated: "If a pediatrician knows me, I would trust a recommendation."

#### CONCLUSIONS

Although mothers will discuss parenting stress and depressive symptoms with their child's pedia-

trician, the richness of the relationships and underlying belief systems that lead mothers to such discussions are complex and multifaceted. Themes that mothers raised include those inherently maternal (emotional health, self-efficacy, and support systems) and those that describe aspects of the interactions that occur between mothers and their child's pediatrician (trust and communication). An ongoing, continuous relationship was perceived by mothers as important to developing both trust and good communication when discussing maternal depression.

Our study revealed several important and somewhat surprising findings. Mothers in our focus groups expressed some willingness to discuss their own concerns with their child's pediatricians, particularly if the pediatrician raised the issue and if they felt there existed a relationship between themselves and the pediatrician. However, many mothers had mixed feelings about involving their child's pediatrician in family issues. Previous quantitative research by Heneghan et al<sup>44</sup> showed that 95% of mothers would welcome or not mind discussing mental health issues with their child's pediatrician. Other investigators have found that mothers consider it appropriate to discuss family stresses and problems during a well-child visit.<sup>45,46</sup> What mothers may report in a questionnaire differs from what we found in our focus groups, namely that mothers would like to openly converse with their child's pediatrician and would offer information when asked if the pediatrician seems "to care." The interpersonal dynamics and strength of the relationship between the mother and the pediatrician, as it is understood by the mother, is an essential element in mothers' willingness to turn to her pediatrician for assistance or information.

Although mothers would like to consider their pediatrician a source of support for themselves, they are fearful of judgment. Mothers' perceived risk of being reported to child protection services in fact may interfere with the discussion of maternal depressive symptoms and parenting stress, which poses a significant challenge to the existing structure of pediatric primary care. Mothers in our sample were very aware of a pediatrician's role as a mandated reporter of child abuse; therefore, they were reluctant to discuss issues that may reflect any difficulties or stresses in parenting their children. Mothers in lower socioeconomic groups were particularly uncomfortable speaking with social workers, because they perceived their role as adversarial rather than supportive. To help mothers with depressive symptoms, pediatricians and social service professionals must rethink their "roles" and encourage mothers to disclose feelings of depressive symptoms without risk of child removal. Most often, mothers with depressive symptoms can and do provide appropriate care for their children. Therefore, a pediatrician who knows a mother well and is able to provide nonjudgmental assistance can intercede with therapeutic rather than punitive motives. Interventions that address maternal depression should pro-

mote improved communication between pediatricians and mothers and enhance efforts to build continuous, ongoing relationships between pediatricians and the families for whom they care. In these ways, the fear of judgment that mothers expressed can be minimized.

Mothers repeatedly stated that they gain strength from other mothers. Mothers in our focus groups developed an almost immediate therapeutic alliance while talking about the stresses of parenting. The spontaneous exchange of information that occurred at the end of every group (from telephone numbers and playgroup and parenting group meeting times to other services of interest to mothers) speaks to the need for future interventions that bring mothers together. Recently, support groups such as lactation and postpartum groups and playgroups have emerged to address the isolation that many mothers experience. The Internet has also become a medium to bring mothers together. For example, Dunham et al<sup>47</sup> created an online support group for mothers in a Canadian community with great success.

The qualitative data collected from mothers in our study was extremely illuminating to describe not only mothers' self-perceptions and feelings about their emotional well being but also about the role their pediatrician can and should play in assisting them with depressive symptoms and parenting stress. Other qualitative studies have been performed in this area. In in-depth interviews with new mothers, Beck<sup>48</sup> found that women with postpartum depression described a loss of control and a "dying of one's former self." Both studies add significantly to the understanding of depression by asking participants to recount and elaborate their experiences, feelings, and perceptions, thus providing a detailed portrait of the process.

This study helps to describe the attitudes and perceptions that mothers have about discussing depressive symptoms within the context of health care for their children. Pediatricians' attitudes are equally important to understand. In a national sample of practicing pediatricians, Olson et al<sup>49</sup> recently described pediatricians' perceived roles, management practices, and encountered barriers in regard to addressing maternal depression. Although 57% believed it was their responsibility to recognize maternal depression, only 7% felt responsible for treatment. Most (66%) did provide some type of brief intervention such as referral to a mental health professional or primary care provider or referral to a support group.<sup>49</sup> Time constraints and incomplete training, but not mothers' fear of judgment, as we found, were barriers raised by the pediatricians surveyed.

Depression and depressive disorders are prevalent, treatable mental health problems<sup>16,50,51</sup> and are especially frequent among women with young children.<sup>1-6</sup> Because of their frequent contact with mothers and the important impact of maternal depressive symptoms on child development, pediatricians are an especially valuable resource in reaching women 15 to 44 years old, a group in which depression is the

leading cause of disease burden worldwide.<sup>52</sup> In fact, the US Preventive Services Task Force recommends screening all primary care patients for depression.<sup>53</sup> Pediatricians are poised to discuss parenting stress or mild depressive symptoms with mothers and to refer those who are more symptomatic to adult health care providers for treatments that are known to be effective.<sup>54,55</sup> Interventions that consider both mothers' and pediatricians' perceptions will ultimately be most successful in assisting mothers with depressive symptoms.

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### **“PAIN RELIEF” CAN BACKFIRE!**

“In the 1860’s a new drug-delivery system, the hypodermic syringe, was perfected. An injection of a small amount of morphine was found to produce the same effect as a larger dose by mouth. Physicians assumed, therefore, that hypodermic injections offered more protection against addiction. Patients with chronic but not life-threatening pain, say osteo-arthritis, were provided with morphine and a syringe and told to inject themselves when there was pain. . . . It took some years to appreciate the mistake, but the sad outcome was that the hypodermic syringe not only did not protect from addiction, but it also facilitated it. By 1920, the president of the American Medical Association, Dr Alexander Lambert of Cornell, somberly stated that ‘nearly 80% of the morphine addicts have acquired the habit from legitimate medication’ provided by physicians. . . . OxyContin was initially marketed as less addicting than other opioids because of a special mechanism that made the tablet release the active ingredient slowly, a characteristic, it was assumed, that would make OxyContin unattractive to mis-users who wanted a big jolt. This assumption was a big mistake. Recreational users discovered that merely chewing the pill would release all of the active ingredient, and produce a powerful high. . . .”

Musto DF. Boon for pain sufferers, and thrill seekers. *New York Times*. December 17, 2003

Noted by JFL, MD

## Will Mothers Discuss Parenting Stress and Depressive Symptoms With Their Child's Pediatrician?

Amy M. Heneghan, MaryBeth Mercer and Nancy L. DeLeone

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