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CHILD EXPERIENCE OF MATERNAL DEPRESSION. CASE STUDIES

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Summary

The aim of this article is to describe the experiences of children whose mothers suffer from postpartum depression. Population studies show that although depression affects about 6% of people in the population, pre-natal and post-natal depression affects 12-20% of women. This means that, at present, in Poland depression and subdepression is experienced by about 48 to over 73 thousand women. Studies show that maternal depression has long-term consequences for cognitive and emotional development, both in infants and pre-school children. In addition, studies show that the mothers' own treatment, both psychotherapeutic and/or pharmacological, while contributing to the reduction of depressive symptoms, is not sufficient to improve the relationship between mother and child. The article presents a review of research of effective interventions with depressed mothers and their infants. It also presents a description of therapeutic work with children whose mothers were depressed in the first 3 years after childbirth.

Infant Sorrow
My mother groand! my father wept.
Into the dangerous world I leapt:
Helpless, naked, piping loud;
Like a fiend hid in a cloud.

Struggling in my fathers hands:
Striving against my swaddling bands:
Bound and weary I thought best
To sulk upon my mothers breast.

William Blake, Songs of Experience, 1794.

Introduction

Postpartum depression affects around 13-20% of women in highly developed countries [1,2]. Additionally, 12% of pregnant women are depressed during pregnancy [3,4]. Depression during pregnancy and postpartum depression are often a continuum: depression experienced during the perinatal period turns into postpartum depression. Avon Longitudinal Study of Parents and

Children (ALSPAC) population studies conducted in the United Kingdom show that the mother's depression, which begins between 2 and 8 months after childbirth, tends to become chronic. Mothers who become ill during this time span are significantly more likely to be depressed 11 years later [5].

According to Beck's study [6], the occurrence of postpartum depression is best predicted by prenatal depression. The DSM V includes the subtype of postpartum depression starting during pregnancy – the distinction of this subtype is particularly important given the increased risk of suicide. Young age of the mother, fewer years of education, depressive episodes in the past, the use of antidepressants during pregnancy, problems with the child's development, low self-efficacy as a parent, difficulties in the marital relationship, and occurrence of stressful life events are other risk factors of postpartum depression which are described in the literature [6]. Psychosocial factors such as poverty, relationship difficulties, stressful life events are more predictive of postpartum depression than biological factors and hormonal changes observed in this time period. Postpartum depression usually lasts from 2 to 6 months, although in some cases it continues for even more than one year. 50% of the offset of postpartum depression occurs in the first three months after delivery and 75% in the first seven months [7].

According to research, maternal depression increases the risk of a child's psychological disorder significantly more than smoking, alcoholism and even emotional and physical violence [8]. Milgrom's study [9] demonstrated a relationship of maternal sensitivity with atypical patterns of infant development and temperamental difficulties in children, whose mothers had postpartum depression at 48 months of the children's lives. Children of mothers with postpartum depression have lower intelligence quotients, what confirms the long-term effects of postnatal depression on the functioning of a child [9]. The longitudinal ALSPAC study, cited above, showed that children of mothers with postpartum depression compared to those of non-depressive mothers experience problems with behavior four times more often (between 3 and 4 years of age), are twice as likely to have difficulties learning mathematics aged 16 years and have a seven times higher risk of depression aged 18 [5].

The first year of life is an important period for the development of the infant's self-regulation, which is one of the reasons why postpartum depression of the mother results in negative consequences for the child's development. Self-regulation of the infant is a competence largely dependent on the interaction with the main caregivers: on their sensitivity and responsiveness to the messages sent by the child. Postpartum depression damages the mother's ability to react responsibly, including the perception of signals sent by the infant, which negatively affects the mother-infant relationship as well as the child's competences associated with coping with emotions and resilience to stress [10]. The depressed mother's difficulties in reacting and interpreting the signals sent by the

child, as well as the interactive patterns, which are used by even a 4-month-old infant in this connection, seem to co-create a mechanism crucial to understanding the impact of the mother's negative mood on her child's development.

We have extensive knowledge about depression in mothers; in most European countries screening is carried out, enabling early identification of women at risk of the disease. However, adequate help and treatment still remain an important dilemma. Although psychological and psychiatric interventions that focus on reducing the symptoms of maternal depression are highly effective, they do not seem to play a protective role in the development of the infant: they do not reduce the developmental risk of the child caused by maternal depression [12–14]. For example, Cooper et al. [7] compared counseling, psychodynamic psychotherapy, cognitive-behavioral therapy, and standard care (treatment as usual). The highest efficacy of treatment has been observed for psychodynamic therapy. Psychodynamic psychotherapy was associated with the reduction of depressive symptoms – as compared to standard care, but unfortunately, the effects did not persist until the measurement 9 months after the end of therapy. A team of researchers led by Logsdon [13] has shown a significant reduction in symptoms of depression 8 weeks after pharmacological treatment (nortriptyline and sertraline). Pharmacology, however, did not affect the quality of parent-child relationships. Interventions that mostly altered the relationship between mother and child were those that included both mother and infant, for example, those provided by experienced nurses. The explicit aim of these interventions was also the improvement of maternal responsiveness [14, 15].

Psychological and pharmacological interventions aiming to reduce depressive symptoms in mothers do not translate into qualitative changes in the relationship with their children, which is an interesting regularity. This might be related to the fact that the evaluated therapies were short-term and did not allow to change the patterns of relations with others. From the psychodynamic perspective, but also based on the results of pharmacotherapy studies [13], the symptomatic improvement in depressed mothers does not change their relationship patterns and depressive mechanisms of personality functioning. Only working on this problem in a long-term therapy provides the possibility to introduce changes in the functioning of close relationships. In addition, as the Beebe research [10] shows, the depression of the main carer changes the interaction patterns in the mother-child dyad. Depression not only affects the functioning of the mother, but also the child. The infant, accustomed to the lack of responsiveness, may send fewer, or altered, interpersonal messages - which may also contribute to the persistent lack of mutual synchrony. One could hypothesize that the combination of therapy with the modeling of certain caring behaviors, which is possible due to the contact of a mother with nurses and midwives, makes it possible to change the patterns of interaction with the infant. Additionally, the results of Salomonsson and Sandel's study [16] show that not all mothers are able to use psychoanalytic therapies. Young

mothers described by these researchers as having an “abandoned’ state of mind: left by their partner or other important people in their lives, perceiving a child as competing with their needs to receive care from others, are not able to effectively use the mother-child psychoanalytic therapy alone. It turned out that, standard, regular and frequent visits of midwives, which were available in the Swedish health care system, were more effective in their case, both for them and for the relationship with the child.

To answer how the depression of the main caregiver affects the child and why the mother's therapy alone may not be sufficient, the analysis of experiments in developmental psychology and clinical cases may be helpful. Depression of the main caregiver is a form of neglecting the child. A specific pattern of interaction between parent and child is shaped during the period, in which the mother, because of her condition, is not able to react sensitively to the infant’s signals [10]. Procedural representations in 3–4-month-old babies are already relatively extensive: infants of this age expect coherent reactions in response to their behavior [17]. Optimal for the development of the baby (including the development of a confident attachment style) is the average range of coherence in the mother-child dyad [18]. High consistency in the relationship corresponds to a state of alarm and is associated with the development of avoiding attachment, while low consistency is associated with inhibiting or withdrawing from contact.

Research, among others that of Beatrice Beebe and her colleagues [10], describe interactive patterns in the dyad infant–depressive mother. As early as in the fourth month of life, the interactive patterns of depressive mothers’ children are different from the patterns of infants with healthy mothers. Depressive mothers, in contrast to non-depressant mothers and their children, have lower coordination of vision patterns and create a common pattern of visual withdrawal. However, both the mother with symptoms of depression and the baby look at each other much longer compared to children in the control group. This pattern is defined by the researchers as “vigilant”. Both mothers and infants are therefore less predictable interaction partners: they look at each other longer but they coordinate less. Despite the reduced coordination of looking, the depressive mothers, in comparison to the control group, have an increased coordination with the child's affect. They are overly excited when their children exhibit positive affect and overly disappointed when their children are irritable or are in a bad mood. Infants of depressive mothers also have increased coherence in the coordination of their touch: they are more likely to touch their mother when her touch is warm and less when she becomes less sensitive and more intrusive. Children from the control group did not coordinate their tactile patterns in this way: they touched their mother regardless of her affect. Coordinating the affective and tactile coordination by children in response to their mothers’ states indicates their interpersonal vigilance. These interactive patterns show that a child aged 4 months can not freely “use” the presence of a guardian, but adjusts his affect and behavior to the affect and

behavior of the mother. These studies also show how the mother's depression interferes with the child's interactive expectations and creates a situation in which the child becomes overly alert to the signals sent by the mother.

Another study, which aimed to understand a child's reaction to the emotional withdrawal of a depressed parent is the *still face* experiment by Edward Tronick[1] [11] – a short film from the study can be found in the web (link in the footnote). This experiment illustrates the importance of contact and ”nonverbal conversation” in the development of a child’s self-regulatory competencies. When the mother stops responding to the baby's non-verbal cues, his/her tension exceeds the child’s self-regulating possibilities: the baby begins to cry desperately. This clearly shows how a baby asks his mother to help him in dealing with tension that he can not handle with. The film also shows how fast the emotional response of the mother, her perception and reaction to the baby's tension brings him immediate relief. The baby, whose messages, behaviors, affections are not reflected by its mother, experiences painful interruptions in contact. The child's feelings, intentions, desires are not reflected by the mother and are not regulated, while this would be necessary for the development of the child's own thinking ability. Infants and young children consistently need their parents - adults who support them in the process of self-regulation and react to signals sent by them: The studies by Tronick [11], Beebe [10] and Jaffe [18] show that in the case of maternal depression this process is reversed and the child withdraws or develops excessive alertness to the signals sent by the mother. According to the Swedish professor Bjorn Salomonsson [19], from the infant's perspective in relation with a depressed mother, the main difficulty of the child is not his fear, caused by the lack of contact and no reaction of the mother but the state of chronic tension. In the situation of maternal depression, the uncontained feelings of a child that have not been elaborated by the mother, return to the child further loaded with complex and often strong maternal feelings. Louis Emanuel [20] believes that a child may unconsciously experience their mother's inability to receive and contain his/her feelings as aversion or even aggression. The state of internal persecution or distress increases, what, in turn, in a vicious cycle, increases the anxiety of the baby. Developmentally, a young infant needs to “push” his feelings of anger, dislike, etc. into his mother with increasing anger, because he hopes he will finally receive an answer. But the answer is not coming or is inadequate: the mother may not react or may react with disappointment and anxiety, which, in consequence, causes the infant to develop a variety of defense reactions from the first months of life. According to psychoanalytic concepts, infants develop diverse, defensive forms of behavior which depend on their temperament and enable them to cope with long periods of their mother's lack of attention, her incoherent or unpredictable reactions. Simplifying, infants have two options:

[1] The film can be watched here: https: //www.youtube.com/watch?v=apzXGEbZht0)

they can identify with the unresponsive, absent mother or quickly over-develop the competences associated with independent coping and independence [20].

I would like to illustrate both types of defense organizations with clinical examples. I will present examples from the individual psychotherapy of two children and parent-child therapy. I will describe the work with children of different ages: the youngest is 3 years old and the oldest is 9 years old. In each of the examples, regardless of the child's age, it can be seen how early experiences contributed to the specific perception of themselves and relationships with others.

Clinical examples

Case study number 1

In the first example, I will present a child identified with an unresponsive, withdrawn parent. A girl, here named "Kasia", like other children who develop similar defenses, avoided eye contact, focused her eyes on the ceiling or objects. Such functioning may be misdiagnosed as autistic disorder. The authors of the DC 0-3 R classification [21] emphasize the difficulty of diversifying pervasive developmental disorders and depressive disorders in children under the age of 3 years. Infants and small children in this group may experience fears of being alone, have difficulties with sucking/eating and sleeping [19]. It is believed that the more the mother is unconsciously destructive to herself, the more difficult it is for her child to separate from her. Below I present the work with a child who functions this way.

The reason for the consultation of the 32-month-old girl with a psychologist was her disturbing behavior. She did not speak and it had been difficult to get in touch with her for more than half a year. She also did not play in a way that would be expected for her age. In addition, the information obtained from the mother revealed that Kasia was still using diapers and ate only selected products – mainly milk, which she drank from the bottle. She often woke up at night with terrible crying and could not sleep without her mother. During the first two consultations, Kasia was lying on the floor in the office, tapping with wooden blocks. She also took other toys – mostly plastic animals, but she limited her play to putting the animals very close to her eyes and turning them. At that time, she did not show any reaction to the voice of her mother or her stories about their everyday life, nor did she have any interactions with me during the meetings.

According to the interview, up to the 14th month of life, Kasia developed normally – however it was hard for me to get any exact data on her infant history and behavior. When she was 14 months old, her mother became severely depressed, she was hospitalized. During a few months of illness, she was lying in bed crying or just looking at the ceiling and not responding. The mother mentioned that Kasia was the only of her children who came to her, lay down next to her and cuddled her.

At the end of the second session, when I wanted to discuss with the mother the referral to a center for the treatment of autistic children, I imitated the girl's behavior for a moment: I tapped the wooden blocks, saying, depending on the intensity of the tapping: *"Kasia knocked quietly, and loudly, very loudly*." After some time, the girl suddenly started laughing, looked at me and repeated my words, saying only their first syllables. She wanted to direct my behavior, saying "*qui*" - when she wanted me to knock quietly and "*lo*" - when I was supposed to knock loudly. This game fascinated Kasia. She continued it throughout the session with some minor modifications. Each time I responded to her words, hitting the wooden blocks quietly or loudly, it made Kasia happy.

For the next consultation, the girl appeared looking quite playfully. She led an incomprehensible dialogue with herself and expected that I would continue to play the "opposite play". The girl's mom seemed dim and very tired. During the first two months of work, a regular "schedule" of sessions developed. They started with Kasia's mom talking about the girl's developmental progress: for example, Kasia had begun to eat more food, showed some interest in family life and relations with her siblings. She was happy to visit the park and the seaside, she had begun to speak. However, she spoke only fragments of words and mostly opposites. The girl had started to speak but this was also for a long time limited to saying only the first syllables of opposite words: fast/slow, big/ small.

After this time, the girl started a constant, repetitive play of hide and seek, which lasted for about three months. The child hid in one fixed place in the office. In the meantime, she expected me and the mother to worry and ask: "Where is Kasia?" Then Kasia appeared and walked towards me and her mother, expecting a cheerful greeting, after which she said goodbye, hid again and the play started again. I understood this play as an attempt to secure Kasia's separation feelings. The girl needed to make sure that after the exciting moment – when she was hiding behind the chair – all the people would be in the same place, which meant that separating did not mean losing. This understanding of fun was also discussed with her mother.

The key disturbing element present in Kasia and the relation with her mother revealed quite quickly. During the play, the girl's mother often turned off, drowned in her thoughts and, as a result, fell asleep. Kasia looked anxiously at her mother's absent face. As observed during the meetings, and probably through the everyday routine of Kasia, this sequence of behaviors seemed to confirm the fears of the child that separation might lead to the loss of a responsive mother. Separation seemed to Kasia not to be a developmental experience, which could be survived. The only way to cope with the fears of separation was to "feel stuck" to the mother, however, the child using such defences could not feel truly alive. It also became clear that the mother and the daughter could not be simultaneously "alive". When the mother was revived, her daughter collapsed into her autistic play, returning to knocking down blocks or figures.

Also, the specific origin of speech development and the fascination with opposites were closely related to the psychological functioning of the girl, her inability to function autonomously. Speaking only the first syllables of words, she needed another person who would finish her saying.

Another game which appeared at each session for the first half of the year was the “family mug game”. The girl took a large mug, which she called ”mom” and three small mugs – ”children”. Saying “now mum feeds her children”, she poured water into the small mugs. When she managed to pour even a few drops into the children-mugs, she poured them back into “mum mug”, saying that mum needed it. She continued the game again and again. In the play, the ”children” mugs were always hungry and could not get anything from the mother mug for longer. The father mug was absent.

The inner image of the mother (in the sense of the possibility of containing) appeared to be characterized as leaky, not able to support Kasia in her attempts of play, development, and separation. During the sessions, the girl did not address her attachment behaviors to her mother. On the other hand, she was afraid of being separated from her. The sporadically observed, lively affect of the girl met with the withdrawal and inhibition of the mother, which seemed to lead to further withdrawal of the child. The girl, as in the studies of Beebe and colleagues [10] seemed to be unable to benefit from her mother's presence, and presented a kind of vigilance: she was focused on observing the affective changes and mimic expressions of her mother. It made her unable to build a coherent, separate representation of herself and experience the freedom to discover who she was. Increased vigilance, anxious observation of her mother’s face and behavior hindered experiencing and in consequence, reliance on her own desires, feelings, intentions. Her desires and intentions seemed to be centered to keep her mother alive what led to confusion between the self and the other. The girl's play with mugs and pouring the water was, in my opinion, an example of recreation of the process of identification with an absent, not reacting object and represented the picture of the dramatic, inner void experienced by Kasia.

Salomonsson [19. p. 89], who described the experience of a child in contact with its depressed mother, and lists the various stages of the consequences of the collapse of the container:

1. Any infant who seeks containment projects onto the mother his/her negative emotions.
2. The problem for a depressed mother is that she finds it so hard to receive and process them. As a result, the infant’s emotions remain in an un-metabolised state. They frighten the baby who becomes restless and fretful.
3. The frightened baby seeks comfort again from the mother. When s/he does this, she is once again drawn into an experience of malfunctioning containment. Alternatively, s/he is reminded of earlier such situations. As a result, s/he avoids the mother or becomes pushy and fretful. Needless to say, this increases the mother’s despair.

4. The baby may experience insufficient containment as a hole or as void. This experience may appear clinically as fears of being alone, breast-feeding difficulties, sleeping problems, for example.
5. At a later stage, the child may seek to counter the void experience by creating phobic objects, which represent a defence formation. It seems more bearable to be afraid of a phobic object than constantly to be restless or in emotional contact with the void experience.

Kasia, for many different reasons, has chosen the experience of void, but this is not the only option the child has. The second possible answer for the lack of attention is to resign from the states of infantile dependency [19, 20] what will be presented in the subsequent clinical vignette.

Case studies number 2 & 3

The second possibility for a child's response to maternal depression is the retreat from dependency. The child becomes self-sufficient and controlling. He/she copes with unsatisfied needs trying to ignore them or to behave as if he/she did not have any. Infants like this are often able to sit alone, without help, at a very early age. They do not rely on their carers, they quickly develop a very strong musculature – not only in a physical but, in a sense, also in a psychological way. They stand alone, begin to walk at 6 or 7 months of age. Their lack of vulnerability to injuries and denial of the possibility of any loss dominates their way of being and is a way to deal with disappointment related to unmet needs. In this way, the child does not need to be in touch with the feelings of loss and disappointment [19,20].

Esther Bick [22] described small children developing a muscular ”second skin” in the absence of maternal containment. Such children could not count on the support of another person and in some way felt compelled to ”stick to themselves.” This type of “second skin” in children can increase the suffering of depressed mothers who already suffer from reduced self-esteem. Those mothers become receptors of the child’s projections of feelings such as susceptibility to injury, helplessness. Not only do they have their own feelings of inadequacy, difficulties in caring for the baby, but they also have to deal with the projections of the baby's feelings [19].

Children, adolescents, and adults with such history may find it difficult to receive help. It is hard for them to understand that a therapist, like a mother, has something to offer [19, 20]. Such patients can increase the sense of desperation in therapists – as they once increased the sense of hopelessness in their mothers. Such children, when they come to therapy, often present omnipotence, lack of vulnerability and a tendency to ”disagree” with the therapist. They can attack him/her in various ways: for example, young adolescents may boast that they have better phones,

better laptops, trying to destroy the ”container” (the office or the therapist). They do not see injuries, low self-esteem, mental pain in themselves, but in the others.

An example is an 8-year-old girl, raised for the first few years of her life by a mother suffering from borderline personality disorder, who underwent pharmacological therapy in an irregular manner. The girl came to the therapist's office saying ”*I took this teacher and threw him out the window, because he pissed me off and upset me. He had to go to the hospital, his head was broken, he was bleeding*“. She also told the therapist to watch her on TV because she would open Euro 2012.

During the first month of therapy, the girl tried to destroy the therapist's office and the toys and objects inside. She chewed toys, made holes in them. After one toy was damaged, she reached for another. The therapist reacted to such behaviors in countertransference with increasing frustration and a strong desire to reject her. Such an exchange might have been an attempt to recreate the situation the girl already knew: rejection of therapy – or the attempt to perceive it as the ”void“ experience. The child also wanted to communicate in this way her early experience of a ”leaky, rejecting“ experience in her early relationship with her carers. Naming the child's behavior – explaining the experienced tension in words that can be thinkable, for example, by saying: “*you may not know whether there is sense to trust another adult”* or *“you bite toys because you are very angry and you do not know how to express it differently“*– resulted in calming the child and created the possibility to play or talk, at the beginning for a couple of minutes, later a bit longer.

Another example of this kind of child reaction to maternal depression is the vignette of 7-year-old Ania, who had difficulties in school adaptation, concentration, and learning. The child had been neglected by her biological family and abused in a family home when she was 3 years old. She was in a foster family. Ania referred to herself as ”nobody”, she did not respond to her name, she followed strangers on the street – as if she did not recognize who she knew and who she did not know. It seemed that there was no psychological “skin”, Ania's representation of herself as a separate person. She expected to look at her all the time, which, however, did not serve the development of interaction or interpersonal exchange. During the first consultation, the girl talked about her plans to kill herself, what made me feel strong anxiety and horror. In my office, the girl was throwing toys and was mostly occupied trying to check if the toys were in the right place. For example, she wanted me to order her more toys, and on the next session, she checked whether they had been bought. She often took scissors and looked at me. It could be assumed that the girl generally aroused a kind of aversion and horror in others. After some time, I connected the vague anxiety that came to me the day before the date of her session, with the history of the girl. Interestingly, at about this time the girl began to play the play of “abandoned child” with me. I think that a representation of her horrible early experiences could begin to create. In her play, the child

had to wait very long and search for her parents. All around her were bandits, they shot, while she stood alone and was exposed to the attacks of wild figures fighting around her. She waited until she almost lost hope, but in the play, her parents finally found her. They came with a big car, which she called ”container“. Despite the great difficulty of focusing attention on one task, Ania was able to build this vehicle very long and patiently. We could talk about this game: for example, saying that when she was waiting for so long, she had a lot of feelings, expectations, anxiety, anger, and rage against the imaginary parents, but also against me – at that time the girl had sessions only once a week.

Discussion

Relationships, the ability to accept and reflect the mental states of the child provide him/her new possibilities for thinking. When we, as therapists, say to infants: “*You saw that your mom was upset when you came out here last time and now you are afraid”* – the baby does not understand our words, but the quiet voice, trying to understand the tension of the child may introduce some kind of solace. To older children we say: “*When you are playing with me, you are reminded of various unpleasant things. But if you were watching fairy tales, you would not have to think about painful things. Perhaps that is why you would like me to buy a television.”*

Building meanings is not just words or a calm voice. It's a message that you can think about feelings and mental states together. The therapist’s comment or hypothesis is not always accurate, but the key is to show that feelings, desires, motivations can have their representations that you can think about together. According to Tronick, every semiotic exchange develops on the path of a certain mess or misunderstanding [in: 23]. On the basis of the microanalysis of video records, Beebe [11] and Jaffe [19] discovered that the average coherence of interaction is optimal for the child's development, moments of misunderstanding and lack of coherence are inevitable. However, it is hoped that the therapeutists’ interpretations will be a kind of accurate translations of children's desires, fantasies and fears: from a more primitive level to a more engaged one. Translation is crucial for the child and it may be particularly important for a child whose primary/main carer suffered from depression or other mental illnesses [24]. A child who has experienced nameless, unrevealed fear in his past and, depending on the conditions, has withdrawn from interactions – as it was described in Kasia's case – or developed hyperactive, controlling patterns of behavior as in cases 2 and 3, may feel understood during the therapy. His incomprehensible behavior may begin to take on meaning due to the creation of representations which can be “thinkable”.

According to research, depression is associated with a specific impairment of mentalization skills. Psychic functioning becomes very concrete, people suffering from depression have no possibility of a more complex representation, and thus understanding of their feelings, internal

states – both their own and that of other people [24], including their children. Their reflective functioning is defined as *hypomentalizing*. Therefore, as shown in the description of Kasia and her mother, both children and their mothers benefit from the common translation of the children's games and comments.

Conclusions

Finally, I would like to emphasize that although these two solutions: identification with a depressive parent and the premature creation of the psychological "musculature" in order not to feel weak and abandoned, are relatively common from the perspective of the clinical work with children and teenager. Certainly, they will not be able to be observed in any situation when the child is exposed to parental affective disorder, as not all children are equally affected by the same traumatic situation.

The cited clinical examples and research in developmental psychology allow us to formulate several conclusions important both for the prevention of parent-child relationships and for the treatment of mothers and children suffering from depression:

1. Due to the prevalence of depressive disorders in pregnant and postpartum women, it is important to adopt a dual-track approach:
    a. by creating a coherent preventive offer for women at risk;
    b. and by a therapeutic offer – in the case of women suffering from depression.

It is worth emphasizing that new standards of maternity care provide for screening for depressive disorders in the first and third trimester of pregnancy. It is not clear, however, where the women who will receive an elevated result in screening will be directed: in large cities, the waiting time for therapy at Mental Health Clinics is even about one year [25]. In addition, therapeutic intervention for sick mothers should also include, in some situations, the modeling of sensitive responses to signals sent by the child. This could be a protective function for the development of a child which is not covered by the mother's therapy. According to Beebe [10], mothers and their children could benefit significantly if the mothers could weaken their alertness to the child's reactions: for example, if the baby turns his head – so that it would not be automatically interpreted by his mother as rejection, but for example, a motivation to lower the level of stimulation. Weakening the mother's over-reaction to the child's satisfaction, but also disappointment and anxiety when the child withdraws from contact, would allow the child to feel more free in their interaction. Mothers could benefit from appreciating the importance of their own interactive stability and predictability and that of their babies, which can be supported, inter alia, by interpretation or psychoeducational interventions and e.g. video communication training.

In the case of children's therapy, it seems important to the therapist's ability to build the

child's distinctiveness: increasing his/her ability to rely on his/her own internal states. Research results indicate that children of depressive parents may not know the situation of reflecting their feelings and mental states, described by the state of ”average consistency of interaction patterns.” Therapy can be such an experience for those children. However, using another person to discover and better understand oneself may not be obvious at all. The depressive parent could have hindered the separation processes, interpreting the autonomy of the child as rejection - which hampered the child's development. On the other hand, excessive autonomy and efficiency of the child may indicate that the child's fear has not been accepted and it develops overly controlling and resourceful ways of functioning so as not to have to experience anxiety, fear, and dependence. In the child's therapy, it is important to broaden his/her ability to experience and tolerate various mental states. Additionally, studies of developmental psychology and research on infants [10, 11, 18] indicate the importance of non-verbal functioning of the child observed during the therapy. Does the child try to tune in to the therapist and in a variety of ways revive him in moments of silence or during breaks in play? Does the child overly watch the face of the therapist, trying to anticipate his reactions or expecting some form of intrusive behavior? These types of procedural interaction patterns can provide hypotheses about the child's early development. Procedural patterns are not included in the child's conscious knowledge of themselves, but talking about them can help the child become more flexible and modify the perception and experience of himself as well as his relationships with others.

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