

# South Australian Perinatal Practice Guideline

# Assessing Parent Infant Relationship

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## Note:

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

## Explanation of the aboriginal artwork:

The aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the aboriginal culture. The horse shoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant woman. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.



**Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that Perinatal services prepare to respectively manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.**

## Purpose and Scope of PPG

The purpose of this guideline is to give clinicians information and guidance in identifying women at increased risk of disrupted early relationship with their infant(s), describing assessment, interventions and support and where to go for additional resources.



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## Summary of Practice Recommendations

Identifying parental vulnerabilities and strengths should begin as early as possible in antenatal care.

Standardised screening tools such as the EPDS and the ANRQ inform clinical judgement about maternal mental health and status.

The aim of parent infant assessments is to identify and understand the strengths, issues and problems facing the family in order to assist in maximising the parenting capacity.

Failure of the infant to connect with a consistent 'other' during early developmental stages will often give rise to recognisable signs.

## Abbreviations

ANRQ	Antenatal Risk Questionnaire
CARL	Child Abuse Report Line
DCP	Department for Child Protection
ed	Edition
e.g.	For example
EPDS	Edinburgh Postnatal Depression Score
GP	General Practitioner
MACRO	Mother and Child Risk Observation

## Definition

Parent infant relationship refers to the connection or bond created between the parent and infant through the exchange of behaviours and emotion communicated between both parties<sup>1</sup>

## Introduction

The earliest relationship with carers underpins infant development, and the consistency and quality of it is a major predictor of social, emotional and cognitive outcomes.

The evolving relationship with the child is influenced by a spectrum of factors which can be assessed using a biopsychosocial framework. Successful interventions using the same framework are best tailored to the family's unique social, cultural and health factors (mental and physical), and will often require a treatment plan that encompasses assistance in more than one domain.

Staff working with parents and infants may become aware of potential or current problems in parent-infant relationship from the patient's own concerns, by observation of the mother and her behaviours towards her fetus/infant or by observation of the infant and his/her relationship with the parent.

Identifying parental vulnerabilities and strengths should begin as early as possible in antenatal care. Standardised screening tools such as the Edinburgh Postnatal Depression Scale and psychosocial screening tools such as the ANRQ are useful in informing clinical judgement about maternal mental health and status. Compromise in these areas may influence the development of a bond with the fetus. Screening tools are used most effectively when they prompt a conversation and ongoing dialogue with the parent, and will in turn help target interventions and help strengthen existing protective factors.

## Assessment

The essential aim of parent infant assessments, whatever the context or setting, is to identify and understand the strengths, issues and problems facing the family in order to assist in maximising the parenting capacity and hence the development of the infant.<sup>2</sup>

There is increasing evidence that the experience of infants in the early years of life has direct and indirect effects on their developmental trajectory. Central within this interplay is the quality of the infant caregiver relationship. A parent's response to an infant's skills and abilities and indeed presence will directly influence how these competencies are further expressed<sup>3</sup>. It becomes crucial then to be able to observe and include information about this aspect of the infant's world.<sup>3,4</sup>

## Risk Factors for Disrupted Early Relationship

- > Past unresolved parental trauma
- > Mental illness, drug and / or alcohol addiction
- > Unplanned pregnancy
- > Cultural and economic factors
- > Traumatic birth experience (for infant as well as parent)
- > Domestic violence
- > Past terminations, miscarriage or death of a child
- > Infant's health status and characteristics e.g. preterm birth, gender, physical health
- > Consistent reports of low mood over more than one trimester<sup>5</sup>
- > Young maternal age (or young parental age more generally)
- > High state anxiety, including specific fear of childbirth

## Protective/ Resilience Factors

- > Prior engagement with therapeutic relationship
- > Ability to reflect and think about the need of others
- > Acceptance of assertive assistance with substance use during pregnancy
- > Proximity, responsiveness and availability of 'significant others' and a commitment from same to be available
- > A reasonably good level of perceived support between the parents.

***Women who identify as Aboriginal have a recognised increased risk.***



***Aboriginal women should be referred to an Aboriginal Health Professional to support their care.***

## Antenatal Attachment: opportunities to understand and support

It is useful to see the pregnancy as a time in which the mother grows her infant in mind as well as body. Therefore, the mother's described perception of her baby usually shows incremental change and development as the pregnancy progresses. Building rapport across this time period therefore is often invaluable; not only to gain a clinical picture, but also to give the mother opportunity to safely explore her changing emotions.<sup>6</sup>

The following domains of enquiry may assist as a guide:

- > **Affect** – maternal mood state, its level of interference with function, and pervasiveness of distress

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- > **Attention** – to the evolving pregnancy- paying attention to the transition from physical aspects towards a sense engagement with “this baby”
- > **Anticipation** – of what may lay ahead- the images and ideas that the parent holds of the infant. For example, has the parent built a picture of an infant that will behave and respond in a particular manner? Do you get a sense of the level of adaptation that the mother will be able to bring to unexpected experience?
- > **Attribution to infant** – Does the mother hold ideas of her baby child that seem related to fantasies of rescue or persecution? For example: an idea that the baby will ‘make things right’, or that he/ she is in some way ‘parasitic’.
- > **Ambivalence** – holding in mind that some degree of ambivalence is normal - the core question being whether the ambivalence has polarised to a point of intolerability and poor function.

## Postnatal Relationship

Some possible questions to the postnatal parent might be:

- > How are things going with your baby? (How are they sleeping / feeding / interacting? How is that for you?)
- > How are things going between you and your baby?
- > Do you feel **happy** with the relationship between you and your baby?
- > Do you feel **confident** with your baby?
- > Some people find it hard to connect to / relate to / understand their baby. Has this ever been a problem for you?
- > What do you **enjoy most** about your baby? (if they struggle to identify anything this should alert you to problems in the relationship)
- > Does your baby make you **feel anxious**? (If so when? In what way? What thoughts do you have?)
- > Do you ever wish you **had not had your baby** or that your baby would go away?
- > Have you ever **felt angry** with your baby?
- > Have you ever **felt like shaking** your baby? Or shouting at your baby? (If yes ask if they have ever done this). Do you ever think of other ways of harming your baby?

Some mothers with **perfectionist traits** and a highly developed sense of responsibility may overstate their shortcomings in relation to their baby. If you suspect this you may be able to clarify the reality by asking about specific situations in detail. It is also advisable to **ask the partner** how they view the relationship between mother and child.<sup>7</sup>

Adapted from <http://www.mothersmatter.co.nz/Medical-Info/Parent-Infant-Relationship/>

The online Postnatal Bonding Questionnaire (<https://www.mothersmatter.co.nz/PBQ.htm>), was devised to screen for problems in the mother-infant relationship. It is usually easy for the parent to complete with the score calculated for you.

## Other Factors to Assess

### Temporal factors

Are there perceived precipitating events and proximal factors that the client associates with any perceived difficulty?

### Baseline function

Is there a distinct variation from the client’s baseline levels and styles of coping before pregnancy and childbirth?

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## **Level of current functional difficulty**

What has been the duration, consistency and severity of expressed difficulty and/or distress?  
On a scale of 1-10 how much is an expressed difficulty at the forefront of the client's daily life, and is there anything that brings change or relief?

## **Ability to form coping and contingency plans**

Is the client on some level able to see the possibility of variation or hopefulness to a perceived difficulty?

## **Paternal wellbeing**

Is the father of this baby seen as having a clear understanding of current and future challenges? Has his behaviour changed in any way that might indicate distress? If the father is not in proximity, is there another identified figure that is seen as a core support?<sup>8</sup>

## **Infant observation**

The earliest task for a newborn is to find homeostasis, therefore this should be held in mind when considering the context of distress. However, the infant is also primed to form a relationship with a carer from birth, and over the first months will be using strategies to do so.<sup>9</sup>

Failure to consistently connect in some form with a consistent 'other' over these early developmental stages will often give rise to recognisable signs.<sup>10</sup> These can include, but are not limited to:

- > Gaze avoidance with parent
- > Flattened affect
- > Lack of spontaneous vocalisations or motor activity
- > Lack of any form of engagement with or curiosity about the clinician **or**
- > Working hard to establish a connection with the examiner whilst seeming to have little reference to the parent

A significant level of one of these signs, or a notable cluster, whilst not diagnostic will signal the need for more monitoring and/ or assessment of the infant.<sup>11,12</sup>

The particular circumstances of the presentation should be held in mind alongside these observations. For example, a tired and unwell child in an unfamiliar setting will often present in a manner that differs from their baseline. Assessment and monitoring therefore should include an overall aim of a longitudinal perspective.

## **Management**

Empathic listening and support for the mother will always be appropriate and sometimes sufficient. For some parents, the invitation and means to access support in the future- 'watchful waiting' – is described as most useful.

Using a biological, psychological and social framework will provide structure for referrals e.g. medical / mental health if significant level of mental illness, psychology referral or social work with specialised parent-infant or family work where more severe problems and availability of specialists<sup>13</sup>.



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## Antenatal care

When difficulties are identified in the antenatal period there is an opportunity to build the relationship between the parent and unborn infant through supporting maternal preoccupation with her unborn child. The mother should be seen as representing a family system and so opening conversation with the couple or significant others can be beneficial.

Health care workers may help the mother to focus on the growing baby and perhaps process difficulties that impact on the forming of the relationship, by for instance talking to the woman about her baby<sup>14</sup>, and encouraging her to attend ultrasound appointments<sup>15,16</sup>, preferably with a partner or friend so that further discussion of the fetus is more likely to occur.

If it is clear that difficulties identified by midwives or in primary care settings that ongoing difficulties are not resolving, input about psychosocial issues or more specialised mental health service involvement may be of benefit.

Referral to specialised perinatal services is possible at metropolitan public hospitals in Adelaide and staff at Helen Mayo House can advise on other pathways (office hours 08 70871030). Women also have access to treatment from psychiatrists, psychologists, GPs and social workers as part of a Mental Health Plan that can be initiated by their GP.

## Antenatal case conferencing

Women identified as a high risk to their baby should have early referral for multidisciplinary case conferencing. A coordinated approach to the issues that may create stress on the development of a normal parent infant relationship in the postpartum period is vital. For example: homelessness, poor attendance for medical care, lack of facilities and planning to take the baby home, previous children removed from care through Department for Child Protection (DCP) involvement.

## Mandated notification

Whilst legislation does not protect an unborn fetus, the DCP should be notified of an imminent high-risk birth through the Child Abuse Report Line (phone: 131 478)

Staff who are mandated notifiers ([see Appendix I](#)) under Section 11 of the Children's Protection Act 1993 have a legal obligation to make a notification to the Child Abuse Report Line (CARL) when they develop a suspicion that an infant is at risk of being abused or neglected.

## Postpartum care

Collaboration between midwives, social work and/ or perinatal mental health services is important to ensure that concerning parent infant relationship are monitored, support provided and ongoing referrals made if appropriate. When significant difficulties arise mother infant therapy may be required to assist in the development of the relationship.

Public and private infant mental health services are available in Adelaide and some rural settings. Information may be obtained through Helen Mayo House in office hours on 08 70871030. Women also have access to treatment from psychiatrists, psychologists, GPs and social workers as part of a Mental Health Plan initiated by their GP.

## Resources

### Useful web based and phone resources - for consumers

- > Post and antenatal depression association  
<http://panda.org.au>
- > COPE (Centre of Perinatal Excellence): dedicated to improving the emotional wellbeing of parents before and during pregnancy, and the year following the birth of a baby  
<http://cope.org.au/>
- > Moodgym- a free web-based cognitive therapy exercise from Australian National University  
<https://moodgym.anu.edu.au/welcome>
- > Black Dog Institute- perinatal depression resources and reading  
<http://www.blackdoginstitute.org.au/public/depression/inpregnancypostnatal/resource/slinksreading.cfm>
- > Australian breastfeeding association- information regarding PND  
<http://www.breastfeeding.asn.au/bfinfo/pnd.html>
- > Beyond Blue: 1300 224 636  
<https://www.beyondblue.org.au/>
- > Child and Youth Health Parent helpline: 1300 364 100
- > Pregnancy birth and baby helpline: 1800 882 436

### Useful web based and phone resources - for clinicians

- > National Perinatal Mental Health Guideline  
<http://cope.org.au/wp-content/uploads/2014/03/National-Perinatal-Mental-Health-Guideline-Final.pdf>
- > Guide to screening tools  
<https://www.beyondblue.org.au/who-does-it-affect/pregnancy-and-early-parenthood/edinburgh-postnatal-depression-scale>
- > Mothers matter. Assessment of Parent Infant relationship. Available from URL:  
<http://www.mothersmatter.co.nz/Medical-Info/Parent-Infant-Relationship/>
- > Children's Protection Act 1993. South Australian Legislation. Available from URL:  
<http://www.legislation.sa.gov.au/LZ/C/A/CHILDRENS%20PROTECTION%20ACT%201993.aspx>
- > Beyond Blue clinical practice guidelines  
<https://www.beyondblue.org.au/health-professionals/clinical-practice-guidelines>
- > GP Psych Support Service: provides GPs with patient management advice from psychiatrists within 24 hours: 1800 200 588



## References

1. Linwood AS. Parent-child relationships. Encyclopaedia of children's health. [cited 2010 Dec 4]; Available from URL: <http://www.healthofchildren.com/P/Parent-Child-Relationships.html>
2. White A. Assessment of parenting capacity. Literature review. Centre for parenting and research, NSW Department of Community Services. Ashfield; 2005. Available from URL: [http://www.community.nsw.gov.au/docswr/\\_assets/main/documents/research\\_parenting\\_capacity.pdf](http://www.community.nsw.gov.au/docswr/_assets/main/documents/research_parenting_capacity.pdf)
3. Weitz, E, Karyotaki, E ; Garber J Andersson G. (2015) The effects of psychological treatment of maternal depression on children and parental functioning: a meta-analysis, *European Child & Adolescent Psychiatry*, v24 n2 237-245
4. Sved Williams A. (2001) Early parent-infant attachment. What can the GP do to help? *Medicine Today*; September: 71-77
5. Belsky J, Rovine M, Taylor DG. The Pennsylvania infant and family development project, III: The origins of individual differences in infant-mother attachment: maternal and infant contributions. *Child Development* 1984; 55: 718-728.
6. Slade A. Keeping the baby in mind: a critical factor in perinatal mental health. *Zero to Three* 2002; 22:10-16.
7. Seymour, M, Giallo, R, Cooklin, A. (2015), Maternal anxiety, risk factors and parenting in the first post-natal year, *Child: Care, Health and Development*, 41( n2 314-323
8. Zajicek-Farber, M (2009) Postnatal Depression and Infant Health Practices Among High-Risk Women, *Journal of Child and Family Studies*, 18: 236-245
9. Mares S, Newman L, Warren B. (2005) *Clinical skills in infant mental health*. Victoria: Acer press
10. Benham, A L. The observation and assessment of young children including use of the infant toddler mental status exam. In: Zeanah CH, editor. *Handbook of infant mental health*. 2<sup>nd</sup> ed. London: Guilford Press; 2000.
11. Nugent JK, Keefer CH, Minear S, Johnson LC, Blanchard Y. (2007) *Understanding newborn behaviour and early relationships: the newborn behavioural observation system handbook*. Baltimore: Brookes publishing.
12. Zeanah CH, Larrieu J, Heller SS, Valliere J. Infant - parent relationship assessment. In: Zeanah CH, editor. *Handbook of infant mental health*. 2<sup>nd</sup> ed. London: Guilford Press; 2000.
13. Zeanah C H, Boris NW. Disturbances and disorders of attachment in early childhood. In: Zeanah CH, editor. *Handbook of infant mental health*. 2<sup>nd</sup> ed. London: Guilford Press; 2000.
14. Sved Williams A & Cowling, V (2008) *Infants of parents with mental illness : developmental, clinical, cultural, and personal perspectives*, Australian Academic Press, Queensland
15. Sedgmen B, McMahon C, Cairns D, Benzie RJ, Woodfield RL. The impact of two-dimensional versus three-dimensional ultrasound exposure on maternal-fetal attachment and maternal health behavior in pregnancy. *Ultrasound Obstet Gynecol* 2006; 27: 245-51.
16. Lynch L, Bemrose S. It's good to talk: pre- and post-birth interaction. *Pract Midwife* 2005; 8: 17-20

## Appendices

### APPENDIX 1 – Mandated Notifiers

**Mandated Notifier** means a person who is required to notify suspicions of abuse under s.11 (2) of the *Children's Protection Act 1993*; and reporting of suspicion that a child or young person may be at risk under section Chapter 5, Part 1, Section 31 of the *Children and Young People Safety Act, 2017*, (this Act will replace the Children's Protection Act 1993 in two phases in 2018); including, but not limited to:

- > A medical practitioner
- > A pharmacist
- > A registered or enrolled nurse
- > A registered midwife
- > A dentist
- > A psychologist
- > A police officer
- > A community corrections officer
- > A social worker
- > A minister of religion
- > A person who is an employee of, or volunteer in, an organisation formed for religious or spiritual purposes
- > A teacher in an educational institution (including a kindergarten)
- > Any other person who is an employee of, or volunteer in, a Government department, agency or instrumentality, or a local government or non-government organisations, that provides health, welfare, education, sporting, recreational, child care or residential services wholly or partly for children, being a person who:
  - (i) is engaged in the actual delivery of those services to children; or
  - (ii) holds a management position in the relevant organisation the duties of which include direct responsibility for, or direct supervision of, the provision of those services to children.



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