Maternal Depressive Symptoms and Infant Health Practices Among Low-Income Women

Esther K. Chung, MD, MPH; Kelly F. McCollum, MPH‡; Irma T. Elo, MPA, PhD§; Helen J. Lee, MA§; and Jennifer F. Culhane, PhD, MPH‡

ABSTRACT. Objectives. To determine the relationships between maternal depressive symptoms and the use of infant health services, parenting practices, and injury-prevention measures.

Methods. A prospective, community-based survey of women attending Philadelphia public health centers between February 2000 and November 2001 was conducted. Women were surveyed at 3 time points before and after parturition. Depressive symptoms were determined with the Center for Epidemiologic Studies Depression Scale at each time point. We studied 6 outcomes, clustered into 3 categories: 1) infant health service use (adequate well-child care and ever being hospitalized); 2) parenting practices (breastfeeding for >1 month and use of corporal punishment); and 3) injury-prevention measures (having a smoke alarm and using the back sleep position).

Results. The sample consisted of 774 largely single (74%), uninsured (63%), African American (65%) women, with a mean age of 24 ± 6 years and a mean annual income of $8063. Forty-eight percent of women had depressive symptoms at 1 or 2 time points (ever symptoms) and 12% had depressive symptoms at all points (persistent symptoms). Compared with women who never had depressive symptoms (without symptoms), women with persistent symptoms were nearly three-quarters less likely to have smoke alarms in their homes (adjusted odds ratio: 0.28; 95% confidence interval: 0.11–0.70) and twice as likely to use the smoke alarm and using the back sleep position.

Conclusions. Maternal depressive symptoms persisting from the prepartum to postpartum periods were associated with increased risks of infant hospitalization and use of corporal punishment and with lower likelihood of having a smoke alarm and using the back sleep position. Additional efforts are needed to identify and evaluate mothers with depressive symptoms to improve the health and safety of young infants.

Depression affects 12% to 48% of mothers with young children. Although depression affects mothers of all socioeconomic groups, the highest rates of maternal depression are reported among low-income women. Risk factors for maternal depression other than low income include young maternal age, low education levels, single marital status, nonwhite race/ethnicity, poor health status, psychosocial stress, and lack of social support.

Maternal depression has been shown to be associated with many adverse health outcomes among the offspring of depressed women, including preterm birth, low birth weight, newborn irritability, developmental delays, somatic complaints, sleep problems, child abuse, and psychiatric and neurobehavioral disorders. Although considered to be attributable in part to genetic factors, some of the behavioral problems observed among children of depressed women are thought to arise from the negative parenting behaviors that these women display. Such negative parenting behaviors include inconsistent discipline and control, unavailability, and emotional insensitivity.

It is unclear how the parenting of depressed women affects the use of health services and preventative practices for their children. A recent study by McLennan and Kotelchuck found that mothers of toddlers and preschool-aged children with high levels of depressive symptoms were less likely to apply preventative practices such as using a car seat and/or using electrical plug covers. Another study, by Mandl et al., showed that women whose newborns experienced ≥1 emergency- or problem-oriented visits in the first month of life were more likely to have symptoms of depression, suggesting that certain patterns of health care use may help to identify some women with depression.

The purpose of our study was to determine whether, among low-income women, associations...
exist between maternal depressive symptoms and the use of infant health services, parenting practices, and/or infant safety measures. We hypothesized that maternal depressive symptoms negatively affect compliance with recommended well-child care visits and the use of preventative health practices.

METHODS

Study Design

This research was part of a larger, prospective, community-based study on maternal stress, birth outcomes, and infant health. Our study included data from 3 surveys, the first of which was conducted with pregnant women at their first prenatal clinic visit after written consent. During a 2-year period, from February 2000 to November 2001, we consecutively recruited women who were receiving prenatal care at a consortium of public health centers in Philadelphia, Pennsylvania. Our inclusion criteria at enrollment were a singleton intrauterine pregnancy and the ability to speak English or Spanish. Ninety percent of all eligible women enrolled in the study. The second and third surveys were conducted with these women in their homes, at ~3 to 4 months and 9 to 12 months after parturition, respectively. Eighty-four percent of all enrolled study participants with known live birth outcomes completed the first postpartum survey, and 85% of those women subsequently completed the second postpartum survey. Eligible study participants were lost to follow-up after the initial survey for the following reasons: 4% refused, 3% moved out of the Philadelphia area, and 9% could not be contacted. Similarly, study participants were lost to follow-up after the second survey for the following reasons: 2% refused, 3% moved out of the Philadelphia area, 9% could not be contacted, and 1% were dropped because of death or severe mental illness. There were no significant differences with respect to race/ethnicity, education, or marital status between study participants who were interviewed and those who were lost to follow-up. However, study participants who were interviewed were on average ~1 year younger than those who were lost to follow-up.

Structured surveys were conducted in English and Spanish by trained female interviewers using standardized questionnaires. At the first interview, we assessed chronic stress, sociodemographic factors, and behavioral practices. The second and third interviews contained information on the health of the child, including maternal reports on the cognitive, social, and behavioral development of the child, and the use of infant health services, parenting practices, and the use of injury-prevention measures. We also asked questions predicting parenting attitudes, the mother’s social support network, and her neighborhood and financial conditions. As part of all 3 surveys, we used the Center for Epidemiologic Studies Depression Scale (CES-D) to measure maternal depressive symptoms. Details of the larger aforementioned study were published previously.27

For this analysis, we included women living with the index child at the time of both postpartum surveys (98% of all study participants) and those who completed the CES-D at all 3 time points. A total of 774 mothers completed all 3 surveys and were still living with their infants. Four mothers were dropped because they did not complete the CES-D at all 3 time points, resulting in a total of 774 subjects.

Study Variables

Maternal depressive symptoms were measured with the CES-D, a reliable valid scale that has been used widely for more than a decade.28–30 We defined depressive symptoms as a CES-D score of ≥16. This cutoff point corresponds to 80th percentile scores for community samples and has a 95% sensitivity for diagnosing major depressive disorder (MDD) among low-income women with the specificity and positive predictive value for MDD are low (70% and 0.28, respectively).29,30 The cutoff point of 16 has been used by many investigators assessing depressive symptoms in a variety of cohorts, including pregnant women.28,31 When studying depressive symptoms during pregnancy, some investigators chose to use a higher CES-D cutoff point (eg, the 90th percentile) to account for the possibility that symptoms of normal pregnancy may overlap with symptoms of depression.9,18 There is no evidence that this approach is more accurate or preferable to using the cutoff point of 16, and the use of higher cutoff points increases specificity but decreases sensitivity for MDD.28 We used a consistent cutoff point of 16 to define depressive symptoms before and after parturition. Mothers were identified as having persistent depressive symptoms if their scores on the CES-D were ≥16 at all 3 time points, as ever having depressive symptoms if their scores were ≥16 at 1 or 2 time points, and as never having depressive symptoms if their scores were always <16.

We studied 6 dependent variables, which were clustered into 3 categories: 1) infant health services use (adequate care and ever being hospitalized); 2) parenting practices (breastfeeding for ≥1 month and using corporal punishment); and 3) injury-prevention measures (having a smoke alarm and using the back sleep position). The dependent variables used in our study were chosen because they are health-related topics that have been discussed widely in the lay press and medical literature and they have all been shown to be related to the well-being of young infants.34–39 Adequate well-child care was defined as the appropriate number of well-child care visits for the age in months, as recommended by the American Academy of Pediatrics,36 and was based on the answer at 3 to 4 months after parturition (second survey) to the following question: “How many times has [child] been to a doctor or nurse for routine well-infant care? Don’t count the times you took your infant for care when he or she was sick.” For this variable, adequate well-child care was determined for each child on the basis of his or her age, providing a 1.5-month allowance. The American Academy of Pediatrics recommends at least 1 visit by 1 month of life, and our criterion for adequate well-child care was having at least 1 visit by age 2.5 months, 2 visits by age 4.5 months, and so forth.

Two other dependent variables were assessed by using data from the second survey, when the infants were an average of 3 to 4 months of age. Breastfeeding for ≥1 month was determined with the following question: “How long did you breastfeed [child] for? How many days, weeks, or months?” Similar to surveys conducted by the Centers for Disease Control and Prevention,40 use of the back position was determined with the following questions: “In what position do you usually put [child] down to sleep? On his or her side, back, or stomach?”

Ever being hospitalized in the first year of life, use of corporal punishment in the past week, and having a smoke alarm in the house were determined with information obtained at 9 to 12 months after parturition (third survey), with the following questions: “How many times has [child] been admitted to a hospital since he or she was born?” “About how many times, if any, have you had to spank your child in the past week?” “Please answer ‘yes’ or ‘no’ to: your home has a working smoke alarm.” For the question on spanking, we dichotomized responses into “0” and “≥1” episode of spanking, with the latter defining use of corporal punishment in the past week.

Control variables that were selected for possible inclusion in ≥1 of the multivariate models were as follows: sociodemographic characteristics (maternal race/ethnicity, education, age, marital status, parity, income, nativity, Women, Infants, and Children Supplemental Nutrition Program (WIC) use, employment, housing stability [measured by address changes and homelessness], and child’s age and insurance status), maternal health behaviors and health status (smoking status, physical health, and postpartum hospitalization), and infant health characteristics (gestational age at birth, birth weight, admission to the intensive care nursery at birth, health status as perceived by the mother, and special medical needs).

Statistical Analyses

Unadjusted group differences were tested by using analysis of variance with Bonferroni posthoc tests (to adjust for multiple comparisons) for continuous variables and the χ² test for categorical variables. To estimate the risk of adverse infant health practices associated with maternal depression, odds ratios were calculated as approximations of relative risks. To adjust for potential confounding variables and to derive maximal likelihood estimates of combined relative odds with 95% confidence intervals, multivariate, unconditional, logistic regression analyses were performed for each of the 6 dependent variables. The α level was set at .05 (2-sided), and Stata 6.0 software (Stata Corp, College Station, TX) was used for all analyses.41
For possible inclusion in these models, candidate risk factors and confounders were identified a priori on the basis of our review of the literature and theoretical considerations. The following variables were included in all 6 multivariate models: maternal race/ethnicity, education, age, income, and nativity. Other variables (maternal parity, housing stability, hospitalization, perceived health status, employment, use of the Women, Infants, and Children Supplemental Nutrition Program, and cigarette smoking; whether the mother was living with a partner; and infant gestational age, birth weight, need for transfer to an intensive care nursery, health insurance, special needs, health status as perceived by the mother, and age at the time of the survey) were included if the adjusted odds ratio differed from the crude odds ratio by at least 10%, which is a well-accepted method of confounder selection when the decision of whether to adjust is unclear.\textsuperscript{42,43} Any variable associated with both the predictor (depression) and the outcome (infant health services use, parenting practices, or injury-prevention measures) at $P < .25$, as suggested by Mickey and Greenland,\textsuperscript{42} was also included. The $\alpha$ level was set at .25 to provide sufficient statistical power to detect important confounder effects.\textsuperscript{44} Interactions (none of which were identified) were assessed by stratification and by testing of interaction terms for statistical significance. Table 3 provides details of the final variables in each of the 6 models. The goodness-of-fit $\chi^2$ statistic described by Lemeshow and Hosmer\textsuperscript{44} was calculated to assess the fit of each multivariate model. This research was approved by the mother, and age at the time of the survey) were included if }

### RESULTS

#### Subject Characteristics and Maternal Depression

Sociodemographic characteristics for the 774 subjects are presented in Table 1. The majority of participants were single, United States-born, low-income, young, African American women. Approximately one half were primiparous. Sixty-three percent were uninsured at the time of the first prenatal visit, and 83% did not have an education beyond high school. Most infants were born at term and were of normal birth weight (Table 1).

On the basis of CES-D scores at all 3 time points, participants were divided into 3 symptom categories: 40% of all participants never had depressive symptoms, 48% ever had depressive symptoms, and 12% had persistent depressive symptoms. Of those who ever had depressive symptoms, 25% had symptoms in the antepartum and postpartum periods, 26% in the antepartum period only, and 49% in the postpartum period only.

The 3 symptom groups were similar with respect to race/ethnicity and marital status. Women who never had depressive symptoms were younger, on average, than women who ever or persistently had symptoms. Those with persistent symptoms were more likely to have less than a high school education, be multiparous, and smoke cigarettes and were less likely to describe their child’s health as excellent (Table 2).

#### Dependent Variables

For our study population, we assessed the overall prevalence of each of the 6 outcomes. Ninety percent of participants reported adequate well-child care for

### TABLE 1. Sociodemographic Characteristics of the Study Population ($N = 774$)*

<table>
<thead>
<tr>
<th>Maternal characteristics</th>
<th>Never ($N = 307$)</th>
<th>Ever ($N = 372$)</th>
<th>Persistent ($N = 95$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American, %</td>
<td>66</td>
<td>65</td>
<td>64</td>
</tr>
<tr>
<td>Mean age ± SD, y</td>
<td>25 ± 6</td>
<td>24 ± 6</td>
<td>24 ± 6</td>
</tr>
<tr>
<td>Maternal status, single, %</td>
<td>72</td>
<td>75</td>
<td>78</td>
</tr>
<tr>
<td>United States-born, %</td>
<td>76</td>
<td>46</td>
<td>51</td>
</tr>
<tr>
<td>Race/ethnicity, African American (%)</td>
<td>65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean annual personal income</td>
<td>$8063$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parity, primiparous, %</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured, %</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school/GED diploma</td>
<td>42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational age, term ($\geq 37$ wk), %</td>
<td>83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth weight, normal ($\geq 2500$ g), %</td>
<td>88</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Based on data obtained at the time of enrollment. GED, General Educational Development.

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### TABLE 2. Characteristics of the 3 Depressive Symptom Groups ($N = 774$)

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Never ($N = 307$)</th>
<th>Ever ($N = 372$)</th>
<th>Persistent ($N = 95$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coutage of every day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses of the Women, Infants, and Children Supplemental Nutrition Program and cigarette smoking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether the mother was living with a partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant gestational age, birth weight, need for transfer to an intensive care nursery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health insurance, special needs, health status as perceived by the mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at the time of the survey</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 3. Associations Between Depressive Symptom Groups and Infant Health Practices*

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Adjusted Odds Ratio (95% Confidence Interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant health services use</td>
<td></td>
</tr>
<tr>
<td>Adequate well-child care†</td>
<td>0.59 (0.33–0.87)</td>
</tr>
<tr>
<td>Ever hospitalized‡</td>
<td>1.16 (0.76–1.77)</td>
</tr>
<tr>
<td>Parenting practices</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding¶</td>
<td>1.10 (0.77–1.57)</td>
</tr>
<tr>
<td>Use of corporal punishment¶</td>
<td>0.84 (0.47–1.52)</td>
</tr>
<tr>
<td>Injury prevention measures</td>
<td></td>
</tr>
<tr>
<td>Have smoke alarm#</td>
<td>0.51 (0.24–1.11)</td>
</tr>
<tr>
<td>Use of back sleep position**</td>
<td>0.28 (0.11–0.70)</td>
</tr>
</tbody>
</table>

* Results based on multivariate logistic regression models, with all models controlling for the following variables (collected at the first survey): maternal race/ethnicity, education, age, income, and nativity.
† Additional variables in the model (collected at the second survey): maternal parity and housing stability and infant gestational age and health insurance. Lemeshow-Hosmer goodness-of-fit $\chi^2(df) = 9.86(8)$, $P = .28$, suggesting a good fit of the logistic model to the study data.
‡ Additional variables in the model (collected at the third survey): housing stability, perceived maternal health status and smoking, and infant age, health status, insurance, and gestational age. $\chi^2(df) = 1.94(8)$, $P = .16$.
§ Additional variable in the model (collected at the second survey): maternal smoking. $\chi^2(df) = 8.39(8)$, $P = .08$.
¶ Additional variables in the model (collected at the third survey): parental health status and infant age. $\chi^2(df) = 1.57(1)$, $P = .21$.
Additional variable in the model (collected at the third survey): infant health services use. $\chi^2(df) = 5.95(8)$, $P = .05$.
Additional variables in the model (collected at the second survey): perceived maternal health status and infant age. $\chi^2(df) = 4.86(8)$, $P = .25$.

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their young infants, and 21% reported their infant ever being hospitalized in the first year of life. Thirty percent breastfed for ≥1 month, and 16% reported the use of corporal punishment in the week before the survey. Ninety-four percent reported having a smoke alarm, and 52% reported using the back sleep position (results not shown).

Figure 1 shows the prevalence of infant health practices for each of the 3 symptom groups, ie, never, ever, and persistent. Women with persistent symptoms were less likely to obtain adequate well-child care, have a smoke alarm, and use the back sleep position but were more likely to have an infant ever hospitalized and use corporal punishment than those who never had symptoms. When the 3 groups were compared, there was no statistical difference in the prevalence of breastfeeding for ≥1 month, but the overall trend showed a decline in breastfeeding rates with increasing depressive symptoms.

Associations between the dependent variables and depressive symptoms, after adjustment for confounding variables, are shown in Table 3. Women with persistent depressive symptoms were nearly 3 times as likely to have their infant hospitalized than were those who never had symptoms (Table 3). Although Fig 1 shows that infants of women with persistent symptoms had a lower prevalence of adequate well-child care, no difference in adequate well-child care was found between women with persistent or ever symptoms and those without symptoms, after adjustment for confounding variables. In the adjusted analysis, there was no association between maternal depressive symptoms and breastfeeding for ≥1 month.

Women with persistent depressive symptoms were nearly twice as likely to use corporal punishment, compared with women who never had symptoms. Those who ever had depressive symptoms were 59% less likely to use corporal punishment than were those who never had symptoms. Mothers with persistent symptoms were approximately one-fourth as likely to have smoke alarms in their homes and nearly one-half as likely to use the back sleep position than mothers without symptoms.

**DISCUSSION**

Few studies have assessed the relationship between maternal depression and maternal use of health services and preventative practices for their children.25,26 This study assessed the relationship between maternal depressive symptoms and the use of infant health services and other infant health practices among women at high risk for maternal depression, ie, low-income, African American women. Our hypothesis was that persistent maternal depressive symptoms negatively influence infant health services use, parenting practices, and injury-prevention measures.

In support of our hypothesis, we found that women with depressive symptoms persisting from the prepartum to postpartum periods were more likely to have an infant ever hospitalized and to use corporal punishment than were women without depressive symptoms. Women with persistent symptoms were also less likely to have a smoke alarm and to use the back sleep position than women without depressive symptoms. Our findings are consistent with the results of a recent study using 1988 and 1991 data, which showed maternal depressive symptoms to be associated with reduced use of car seats and electrical plug covers, as noted above.25

Infants of women with persistent depressive symptoms were nearly 3 times more likely to be hospitalized in the first year of life than were infants of unaffected women. In our study, we did not determine the reason for hospitalization; therefore, it is difficult to know to what extent the hospitalizations were preventable or related to ambulatory care-sensitive conditions. Additional studies are needed to determine why infants of women with persistent depressive symptoms are more likely to be hospitalized than infants of mothers without symptoms.
Mothers with persistent depressive symptoms had twice the likelihood of using corporal punishment with their infants at ~9 to 12 months of age than mothers without depressive symptoms. This result raises concerns, because child abuse has been linked to maternal depression.21 The increased use of corporal punishment may not be surprising, because depressed mothers have been shown to display many of the characteristics of abusive mothers, often showing hostility and negativity toward their children.22-24

Women with persistent depressive symptoms were much less likely to have smoke detectors in their homes and to use the back sleep position for their infants than were women without depressive symptoms. The reduced use of these important preventative measures may be attributable to many factors. Depressed women, compared with unaffected women, are more likely to live in adverse circumstances, have fewer supports, be withdrawn and unavailable to their children, be distracted or preoccupied with their own mental health issues, or be hospitalized.45,46 It may be difficult for mothers to focus on preventative measures if they are dealing with more immediate and pressing needs.

Nearly one half of the women (48%) studied had depressive symptoms sometime during their pregnancy and/or in the year after the birth of their child. Of those women, 49% had postpartum depressive symptoms. As many as 1 in every 8 women had persistent depressive symptoms from before parturition to after parturition. Given the high prevalence of depressive symptoms among low-income women and the association between depression and adverse infant health outcomes, programs should be developed to assist women with depressive symptoms with their parenting and understanding of child development.

Our study has several limitations. This study of low-income women in Philadelphia may not be generalizable to all women with young children. We used the CES-D to measure depressive symptoms, but we did not determine whether the women had MDD or other psychiatric illnesses. Although the sensitivity of the CES-D among low-income women is high, the positive predictive value remains low.30 Data obtained in our study were based on maternal reports, which may be subject to reporting bias; however, there is no reason to suspect differential reporting among the 3 symptom groups.

The rates of adequate well-child care, as determined by the number of well-child care visits, were high (≥85% for each symptom group) and did not differ among the 3 groups in the adjusted analysis. Although this finding was not significant in the multivariate analysis, we did notice a trend in the bivariate analysis toward a decline in adequate well-child care rates with increasing depressive symptoms. The prevalence of adequate well-child care was highest among women who were never depressed, followed by those ever having and persistently having depressive symptoms. Our relaxed criteria and early assessment of well-child care in the first 3 to 4 months of life might have resulted in overestimates of adequate well-child care. This might have biased our findings toward no effect. Additional studies examining well-child care among older infants and children may be necessary to determine whether an association exists between maternal depressive symptoms and adequate well-child care. Similarly, we did not find an association between depressive symptoms and breastfeeding rates in our adjusted analysis. Although the overall trend in the bivariate analysis showed a decline in breastfeeding rates with increasing depressive symptoms, this finding was not statistically significant.

Findings from our study support previous studies, which have called for increased screening, detection, and treatment of maternal depression. Developing strong relationships between health care providers and families on a continual basis may be the first step toward detecting depressive symptoms among mothers of young children. African American and low-income women, who are at high risk for depression, are unlikely to seek care in mental health care settings and often use primary care settings for treatment of their psychosocial problems.47 A recent study by O’Malley et al48 found that primary care providers who met all of the medical needs of low-income, nonwhite women and had sustained relationships with their patients were more likely to ask about and treat for depression. Similarly, mothers assessed by their child’s primary care provider were more likely to be identified accurately as having depressive symptoms, compared with those who were assessed by a trainee or nurse practitioner.49

Screening and treatment for depression should begin during pregnancy, because as many as 50% of women with postpartum depression report symptoms of depression before parturition.50 Health care professionals who provide obstetric care, ie, family physicians and obstetricians, have an obligation to treat pregnant women with depressive symptoms and/or to refer them to mental health care providers. Some have advocated the use of validated screening tools as part of routine care in the postpartum period.51 Such tools, including the CES-D and the Edinburgh Postnatal Depression Scale,52 have been used previously and may assist clinicians in detecting women with significant depressive symptoms and those at high risk for MDD. Others have suggested asking simple screening questions based on criteria in the Diagnostic and Statistical Manual of Mental Disorders (4th ed), such as, “Have you had a depressed mood . . . nearly every day for the past 2 weeks?”53 There is evidence to suggest that asking the following 2 questions may be as effective as screening with longer instruments: “Over the past 2 weeks, have you felt down, depressed, or hopeless?” “Over the past 2 weeks, have you felt little interest or pleasure in doing things?”54

Pediatricians can play a role in detecting signs of maternal depression and also can serve as advocates for their patients. Attitudinal and educational changes must be made, because several studies showed that the current attitudes and skills of pediatricians limit their ability to recognize and assist in the management of maternal depression.49,55 In gen-

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eral, primary care providers infrequently inquire about and treat depression.49 Primary care providers should refer women with evident depressive symptoms to mental health care professionals for evaluation and treatment. Novel approaches are needed to diagnose and treat maternal depression. Primary care practices should consider a multidisciplinary approach, incorporating social workers, psychologists, and psychiatrists as part of a group practice.

This study provides additional evidence that maternal depressive symptoms have negative effects on maternal use of infant health services and preventative health measures for their infants. The increased risk of infant hospitalization and the rates of using corporal punishment, having a smoke alarm, and using the back sleep position found in this study highlight the need to identify and evaluate maternal depressive symptoms to improve the health and safety of young children.

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