Maternal representations and risk factors for depression in the migration process

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Abstract

During pregnancy and after childbirth women develop specific representations, expectations and fantasies about themselves and their children. Pregnancy involves both physical changes and relational and affective ones. The mother's role is a culturally transmitted element that conveys values, myths and rules; birth can be considered as a cultural event with unique characteristics. A multi-factorial model is useful for tackling motherhood and depressive symptoms in migrant women, before and after delivery. The aim of this study is to analyse the motherhood experience in migrant women; data were collected during pregnancy and after delivery in order to evaluate maternal representation (IRMAG, IRMAN), family relationship representation (DSSVF) and levels of depression (EPDS). The results of this study show that migration processes could increase vulnerability in first-time mothers, who might *feel exhausted, upset and* experience *feelings* of *loneliness* due to a *lack* of support from significant figures.

Key-words: pregnancy; maternal representations; birth; migrant women; native country.

Introduction[1]

We consider pregnancy as an event that should be inscribed in a evolutive perspective; women need to elaborate the critical event of pregnancy in relation to personal identity, family relationships and relationships between couples. Motherhood offers a new way of seeing oneself because women start questioning their female models, they try out new social roles and new relationships with their partners, in order to create space for the newborn child all relationships in the nuclear family need to be re-arranged and the distance from the family of origin needs to be remodified (Malagoli Togliatti & Lubrano Lavadera, 2002; Scabini, 1995).

The most important change in parenthood regards nurturing, the task of taking care is perceived as the most significant change within the family life cycle (Nyström & Öhrling, 2004); the birth of a child, with all these new tasks, might sometimes provoke negative feelings. Pregnancy, delivery and puerperium are related to physical change, pain, health concerns for the child, and also with the personal experience of losing one's independence and create new priorities in everyday life (Rutter & Rutter, 1992).

This deep transformation during pregnancy regards the inner and external world because motherhood is a mental state; during pregnancy and soon after child birth, women may express different typologies of affective disease (Born, Zinga, & Steiner, 2004). Bydlowsky's concept of mental transparency (Bydlowsky, 1997) might help us to understand the greater vulnerability that women face during and after pregnancy; psychic functioning becomes more explicit, unconscious representations become more clear and one's emotional life seems to have a more direct expression.

Postpartum depression is a clinical condition that might occur after childbirth; women with PPD have multiple symptoms such as depressed mood, markedly diminished interest in pleasure in everyday activities, significant weight loss or weight gain, sleeping disorders, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate, or indecisiveness, not having any interest in the baby or being overly worried about the baby or afraid of hurting the baby, recurrent thoughts of death and recurrent suicidal ideation (APA, 2000). With regard to PPD it is important to distinguish between maternity blues and postpartum psychosis because maternity blues has minor symptoms that tend to regress in a short time; on the contrary, postpartum psychosis can last for up to 90 days after childbirth. It is a serious disease that can affect new mothers soon after childbirth with symptoms of depression, losing touch with reality, hallucinations, agitation, bizarre feelings and behavioural problems (O'Hara, 1999).

With regard to the migration process we focused on those elements that could be identified as precursors of a depressive syndrome and which might represent specific risk factors for postpartum depression.

Searching for risk factors for postpartum depression is a hard task because we have to consider multiple variables in different dimensions: biological function (hormonal change), environmental characteristics (socioeconomic status, social isolation, social expectations of motherhood), obstetric and gynaecological condition (obstetric complication, lack of support during delivery), psychosocial variables (life-stressing events, unsatisfactory couple relationships, lack of social support, social stigma of postpartum depression) and psychological factors (previous depression symptoms, a difficult mother/daughter relationship, child temperament, negative beliefs about oneself and one's children) (Caretti & Crisafi, 2009).

Empirical research and clinical experience tend to stress that migration is a familial experience, and for this reason it is important to understand what migration means to mothers and pregnant women (Cattaneo & Dal Verme, 2005; Chinosi, 2002; Moro, 2002, 2005; Scabini & Rossi, 2008). Becoming a mother abroad might represent a risk factor caused by difficulties with regard to migration processes; migrant women have left their relatives and cut off their links with their places of attachment, in their search for a better place to live, but without clear plans for their future. Refugee women have left their native countries in order to survive, thus enduring an obligatory exile and a

[1] The introduction was written by M. Vinciguerra; paragraph 1. was written by A.M. Di Vita and P. Miano, paragraph 2. and conclusions were written by A. Ciulla.

rupture in their personal and familial history (Moro, 2008); adjustment to a new context is always associated with perceived social support and maternal representations during pregnancy and puerperium (Camilleri & Cohen Emerique, 1989; O'Hara, 1986; Romito, 1992). Various researchers suggest that the psychic condition of motherhood is supported by tradition and a shared role with regard to motherhood, which convey knowledge and the practice of caring (Balsamo, 1997; Balsamo, 2003; Di Vita, Errante, Salerno, & Vinciguerra, 2004; Di Vita, Errante, & Vinciguerra, 2005, 2006; Taliani & Vacchiano, 2006).
Migration may increase vulnerability in women who feel a sense of inadequacy with regard to newborn children and their role as mothers, whereas parenting self-efficacy is a mediating factor in a model of maternal postpartum depression (Elder, 1995); parental self-confidence boosts positive responses in children, which in turn enhance the parent-child relationship (Bornstein, 1995; Gondoli & Silverberg, 1997; MacPhee *et al.,* 1996; Teti & Gelfand, 1991). As Moro (2005) points out, lack of social support could lead to a sense of void that diminishes the capacity to understand and elaborate difficulties with motherhood and caring; without good adjustment, western methods of treatment (gynaecological visits, echography, amniocentesis, epidural anaesthesia, caesarean delivery) are seen by migrant women as incomprehensible and invasive experiences (Campagnola *et al.*, 2007; Dusi, 2007; Gozzoli, 2008).

Clinical evaluation of motherhood

There has been an increasing interest in studying how a mother's caring might influence child development, focusing on risk factors such as postpartum depression, which might reduce emotional, cognitive and relational development (Ammaniti, Sergi, Speranza, Tambelli, & Vismara, 2002; Bradley *et al.,* 2001) or life conditions, which in a family system could increase vulnerability to trauma, neglect, abuse and developmental delays (Grussu & Quartaro, 2006; 2007; Quartaro, Grussu, Nasta, Fede, & Cerutti, 2000).
On these bases we conducted research with 87 primiparous migrant women[2], aged between 19 and 34 years old, benefitting from the special migrant gynaecological services of the University Hospital of Palermo and Messina; none of these women reported pregnancy risk factors. We identified two aims for the research: a) to explore maternal representation during pregnancy and at three months after childbirth, b) Family relationship changes as a consequence of pregnancy and postpartum.
To evaluate maternal representation two different measures were used:

- an adapted version of Interview for maternal representation during pregnancy - IRMAG (Intervista per le Rappresentazioni Materne in Gravidanza; Ammaniti, Candelori, Pola, & Tambelli, 1995);
- an adapted version of Interview for maternal representation at childbirth - IRMAN (Intervista per le Rappresentazioni Materne alla Nascita; Di Vita & Giannone, 2002).

The administration of DSSVF (Symbolic drawings of the family life space, Gilli, Greco, Regalia, & Banzatti, 1990) allowed us to evaluate the quality of family relationships. The IRMAG interview consists of 41 questions and analyses various issues: mother's and father's desire for parenthood; emotional reaction of mothers, fathers and families to revelation of pregnancy; emotions and changes during pregnancy in the woman, in the couple and in the woman's relationship with her own mother; fantasies about childbirth; feelings, emotions and fantasies about the baby inside; future expectations about maternal role, parental style and mother-child relationship; temporal inner perspective about subject's role as daughter and as mother.
The post-delivery IRMAN interview evaluates changes in the narrative model after childbirth. In particular it examines: the mother's perceptions, emotions and fantasies about the baby; caring practices and emotional involvement; changes in the relationship in the couple and that of the subject and her own mother.

[2] Their native countries were Bangladesh or Sri Lanka (21%), Romania and Poland (20%), Mauritius (15%), Guinea, Ivory Coast, Ghana, Nigeria (14%), China (12%), Arab Maghreb Union (5%), Balkan area (5%), Ecuador, Dominican Republic, Peru (4%) or other countries (4%).

Both the interviews analyze women's representations during pregnancy and after delivery, as regards two issues: self-representation as mother and representations of the baby. These two issues were analyzed via seven dimensions (richness of perceptions, openness to change, range of involvement, coherent narrative structure, differentiation between representations of one's self and the baby, social dependence, fantasies); each of these was evaluated in relation to specific items in the interview.
The interview coding system by Ammaniti and colleagues (1995) was used to also evaluate the post-delivery interview, IRMAN (Di Vita & Giannone, 2002); the coding system consists of three representational categories and further subcategories:
1) "integrated/equilibrated" representations: this category indicates that women present a rich and coherent narration of their pregnancy as an element of their femininity;
2) "restricted/disengaged" representations: this category indicates that women feel pregnancy as a necessary phase in their life; women try to control themselves and their narration is poor, lacking information about both psychological and physical changes;
3) "not integrated /ambivalent" representations: this category indicates that narration is contradictory and women show ambivalent tendencies with respect to pregnancy, motherhood and the baby. Narrations are poorly integrated and sometimes confused.
In order to evaluate how changes in the family system might influence the representations of family relationships, we administrated, both before and after childbirth, symbolic drawings of DSSVF. By evaluating the use of space this projective test is able to represent the psychic reality. The DSSVF consists of a circle, drawn on a sheet of paper, which represents the family system; the space outside the circle represents the social system. During DSSVF administration the subjects are asked to draw themselves symbolically as well as other significant persons in their lives; they then add important events and various organizations (for instance, associations, services, institutions, etc.). Finally the subjects are asked to distinguish the relationships between themselves and others (good, conflicting, so-so, poor).[3] and to indicate boundaries and communications between what is inside and outside the circle.
After a focus group regarding mothers' psychological problems a few months after delivery, thirteen migrant women participated in the second stage of the research. Our aims were to recognize risk factors for depression, to be evaluated with the Edinburgh Postnatal Depression Scale - EPDS (Cox, Holden, & Sagovsky, 1987; adapted by Benvenuti, Ferrara, Niccolai, Valoriani, & Cox, 1999).
The women were aged between 18 and 28 and their native countries were: Morocco (3), Sri Lanka (3) and Romania (5). Eleven women completed all the tests before and after delivery. The aim of this second stage was to support the mother-child dyad, with special attention to migrant women and their needs. Risk factors for depression were measured, during pregnancy and three months after childbirth, using the Edinburgh Postnatal Depression Scale - EPDS (Cox, Holden, & Sagovsky, 1987; adapted by Benvenuti, Ferrara, Niccolai, Valoriani, & Cox, 1999), a 10-item self-assessment rated on a 4-point Likert-type scale. With regard to the EPDS, various studies showed the validity of the questionnaire; it manages to distinguish between different levels of depressive symptomatology (Cox, Holden, & Sagovsky, 1987; Cox, Holden, 2003) and is useful for assessing postpartum depression (Agostini, Monti, & Martini, 2004; Murray & Carothers, 1990). Some studies confirm that severe depressive symptoms, or incomplete remission, also represent an obstacle to child development (Murray et al., 1996) and children of (previously) depressed mothers – evaluated with EPDS - tend to represent their mothers as less joyous (Edhborg, Lundh, & Seimyr, 2001).
It is necessary to underline that EPDS data are not sufficient to diagnose a postpartum depression; the self-report was actually created in a prevention perspective and even though it enables us to recognize risk factors, it does not identify depression symptoms. In other words, high scores at EPDS reveal a higher possibility of experiencing depressive symptoms, though in order to obtain the right diagnosis it is necessary to proceed with further clinical evaluation.
Our results suggested a prevalence of "restricted/disengaged" maternal representations (58% in the first group and 50% in the second one) associated with a diffused representation of relationships between the subjects and significant other persons: mothers drew themselves in the centre, but at a distance from others. "Integrated/equilibrated" maternal representations (26% in the first group and

[3] For a detailed description of measures with different administration procedures (joint, individual, concerning the present and/or the future etc.): Gilli et al. (1990); Gozzoli & Tamanza (1998).

35% in the second one) were associated with a graphic representation of very positive relationships with relatives and the community.
Furthermore "not integrated /ambivalent" representations (16% in the first group and 15% in the second one) were associated with a peripheral representation of themselves, in which significant other persons are drawn quite far away.
The results of the EPDS were analyzed from a prevention perspective and not for diagnostic purposes. Six of the eleven participants reported non-pathological scores at the first administration, while the other women had a score that equalled or was higher than the cut-off score of 10. After childbirth, in some cases, the scores tend to increase and in others decrease (table 1). We can interpret this data by looking at the differences between the mother's child representation before and after childbirth. We might suppose that for some women the baby could represent a protective factor, associated with a lower score at the EPDS, whereas for other participants parental transition could increase vulnerability to depression.

Table 1
Edinburgh Postnatal Depression Scale Scores

Subjects	FIRST ADMINISTRATION 5°-7° MONTHS OF PREGNANCY	SECOND ADMINISTRATION 3 MONTHS AFTER DELIVERY	DIFFERENCE BETWEEN FIRST AND SECOND ADMINISTRATIONS
2	14	17	3
3	11	5	-6
4	14	16	2
5	7	6	-1
7	8	7	-1
8	10	12	2
9	9	11	2
10	9	11	2
11	14	10	-4
12	8	13	-5
13	8	3	-5

The transition to parenthood[4] affects the family system, within the couple, the families of origin, and significant relationships. The symbolic drawings of family life space - DSSVF (Gilli, Greco, Regalia, & Banzatti, 1990) explore how close relationships change from pregnancy to the first months after childbirth. Relationships are seen from the subject's perspective so that we have an image of what they think and feel about their motherness within their relationships.
Participants tend to create DSSVF with one similar characteristic. All the drawings are quite poor; the women put themselves in a peripheric position compared with others figure in the family life space; husbands are often put in the middle, and during pregnancy they include neither the baby nor community organizations (public or private, formal or informal); the pregnancy seems to be the most important thing in their lives and there aren't any other events that they take into account.
The DSSVF of a Moroccan women (23 years) could be an interesting example of a family relationship for migrant women during pregnancy; this drawing is characterized by restricted relationships, both during pregnancy and after childbirth, and all significant others are placed outside an empty circle representing the family. The couple is closed within a rectangle under the circle and

[4] The construct of transition to parenthood comprises a series of changes deriving from the assumption of the parental role and the resolution of related developmental tasks.

members of the families of origin are quite distant, and they too are closed in two different rectangles. The subject and her husband are isolated, without any relationships, and alsono significant person or event is inserted. It seems that this couple cannot have contact with others; their two families are tied together and their communication has a positive evaluation, but we have a clear sign that the couple experiences feelings of loneliness. The baby is not included in the first DSSVF and in the second one the subject put herself, her husband and their daughter closed in a small circle near the big one; the only person in the circle is the subject's mother, the only one that is involved in a close and positive relationship.
Interviews were analysed looking at several central issues of research.
During pregnancy anxiety and depression factors emerged from interviews and women talk a lot about how they feel:

Before I had a job, now I've stopped...now I can't go out...I can't eat a lot and I can't do a lot of other things...I stay in bed, I don't get up in the morning to clean for example. I just know that I am frightened and nothing more...my mother told me not to be worried, but she is my mother, what else could she tell me? The baby doesn't move about a lot, twice a day, especially if I don't eat or if I am angry or when I get out of bed. I dreamed about a baby s crying and I wasn't able to see the baby (18 years, Romania).

I was very worried...when I went to my mother, she took care of me, she arranged a lot of things...I felt like a child and I felt powerless (18 years, Romania).

I felt bad inside...I couldn't get up in the morning, I was sad, I felt alone and I wished to be close to my family (23 years , Sri Lanka).

I am a little bit worried...but I don't tell anyone...I am frightened...I don't know what to do...even if I hid at the beginning I felt anxious...I would like to be less anxious (28 years, Sri Lanka).

During pregnancy women seem to be more anxious if they reflect on elements of planning; at the question: *What do you think will be necessary for your baby during the first months?* Participants tend to become anxious when they think of parenting skills and most of them think that they will need to receive medical help. After childbirth, as well as preoccupation and anxiety, women tend to feel more and more insecure about their capacity to be able to take care of the baby:

I always feel very tired, I don't have time and I have a lot of things to do and I always have to look after the baby (27 years old i, Sri Lanka).

It is possible that mothers feel exhausted and upset when considering their children's total dependence on themselves and sometimes, during the post-delivery interview, the women report fantasies about death or illness:

She depends on me...she can't live without me (23 yearsi, Sri Lanka).

This kind of preoccupation and feeling of depression could became an obstacle to mother-child relationships as some participants state during the post-delivery interview:
It is an arduous task, in the night you don't have any energy...there are moments when he is crying and you don't know why, so you feel desperate and you don't know what to do...when he keeps on crying. My husband supports me when I am sad, sometimes I think about my unborn children (referring to previous abortions). I am frightened that something bad could happen to him (28 years, Romania).
I was frightened because I was alone...I felt discouraged, I cried. I didn't imagine that it would be so hard. I am frightened and I am scared...I lost my mother when I was a child and I remember that I was crying and how I felt alone, I don't want my child to feel alone...when we were children we suffered (referring to her husband), we lacked just about everything... I feel melancholy because I am alone...I feel alone...I don't know what to do on my own with the baby...I'm about to cry... at least if I was in my

native country , but here I don't know who can help me...it is bad when I am alone with the baby and he cries or I have something to do but I can't leave him alone (27 years, Romania).
I was scared to death and I was frightened that the baby would die...in Romania one of my girlfriends had a baby and he died in the cradle because she wasn't looking after him. I am worried that something could hurt him and that something bad could happen, an illness that I could prevent by being more careful. When he cries and I don't know why then I get scared (27 years, Romania).

I have been worried about my baby and I would like someone to take care of me or of her for a little bit, so that I could take care of myself. Sometimes I feel so tired that I would like to fall asleep, without knowing anything, and wake up in a couple of years (23 years, Morocco).

Discussion

A considerable amount of literature has been published on motherhood and depression (Aceti, Aveni, Giacchetti, Motta, & Straniero Sergio, 2010; Guarino, Ammaniti, & Papaccio, 2010), we know that postpartum depression could occur in various cultural contexts but there is one element that may influence the expression of depressive symptoms, attribution of meaning to depression during pregnancy and after childbirth. Migration seems to be an important factor in explaining postpartum depression because migration processes could lead to a condition of privation, exclusion and powerlessness (Gozzoli & Regalia, 2005); these variables are included in a multifactor model of depressive symptoms in pregnant women and mothers during the first months after delivery. In this perspective postpartum depression is not a women's problem but concerns the family as a system and is influenced, in particular, by the interpretation of symptoms and family organization (Downey & Coyne, 1990).
Becoming a mother for the first time always leads to a new definition of identity and increases vulnerability with regard to self-esteem, self agency and ego resiliency; in an intergenerational perspective, during pregnancy and after delivery, women tend to elaborate new relationships with their mothers and others significant figures from the family of origin. After leaving their native country, adjustment to a new context takes some time and pregnancy represents an event that could intensify feelings of incertitude and insecurity. The results of this study show that migration processes could increase feelings of loneliness in new mothers, due to a lack of support from significant figures.
Most of the subjects reveal "restricted/disengaged" maternal representations, their accounts about motherhood tend to be incoherent, rigid, poor with in emotional content and focused on rational processes rather than inclined to freely imagining their life with the baby. Findings from DSSVF are consistent with those from interviews and children are probably not represented in the drawings because women have still not constructed a clear image of their babies; moreover, subjects tend to put themselves in a peripheric position, which shows an image of themselves as isolated beings.
We might consider childbirth as a factor that could increase psychological problems; anxiety, fear and insecurity, already present during pregnancy, tend to increase after delivery and this is especially true, three months after birth, in maternal representations.
People in all cultures have values, beliefs and myths that regulate pregnancy, delivery and caring, so that, lacking symbolic references and sound traditional practices, women might feel confused and western practices might intensify the sense of strangeness and maternal inadequacy. However, in the present study, the influence of the women's local cultures was not evaluated, because of the heterogeneity of the subjects' origins and the small group-size.
Although the migration process is associated with an experience of social withdrawal that can increase insecurity, anxiety and depression, especially in conjunction with other critical periods of transition (e.g. parental), these results need to be interpreted with caution because of the small sample size, which does not allow us to generalize regarding our results; a second limitation of this study is the use of EPDS, which evaluates risks for depression, but does not permit an accurate diagnosis of postpartum depression and does not distinguish between severe/light symptoms or chronic/transitory symptoms. Furthermore, the two interviews, IRMAG and IRMAN, administered respectively during pregnancy and three months postpartum and used in a special version adapted for foreign mothers, are "culturally" connoted instruments that have only been verified on Italian women.

Conclusions.

With regard to practical implications we would like to emphasize that researchers need to take into account cultural differences regarding parental roles and caring tasks (Sponchiado, 2004).
The limitations of our research are due to the scarcity of samples, the impossibility of generalizing results and the issue of the varied cultural provenance of the women who took part in the research. In fact, measures were administered to subjects whose mother tongue was not the same as the language used for the items. Even though all the women had a good level of comprehension of Italian, we can not exclude possible misunderstandings about certain concepts (family, couple relationship, etc.).
Research into parenting and mother-child relationships is necessary to establish social intervention, to promote mother-child health and to evaluate risk factors for depressive symptoms.
Hospital treatment should be planned by taking into account cultural differences and the migrant women's traditions with regard to motherhood (Moro, 2002) to make it easier for new mothers to construct a positive relationship with their children.
A multi-factorial model is useful for tackling motherhood and depressive symptoms in migrant women, before and after delivery; Moro (2008) has examined how cultural factors influence both the mother's role and mother-child relationships and she has suggested that a trans-cultural perspective, permitting the sharing of beliefs and interpretations about motherhood, might enable migrant mothers to have a positive outcome and to avoid negative consequences.

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