# Assessing mother-infant interaction and safety of the woman and infant

## A guide for health professionals

**The following table provides a list of prompts to assess difficulties in the mother-infant relationship[1]. The list is not exhaustive and is not intended to be used as a checklist or formal assessment tool. Rather, it indicates areas of functioning that are important to the mother-infant relationship. If any concerns arise, consulting with and/or referring to the appropriate specialist service is a consideration.**

| PSYCHOSOCIAL RISK FACTORS | RELATIONSHIP FACTORS (OBSERVED OR REPORTED) |
|---|---|
| • Unresolved family of origin issues | • Is the mother thoughtful about her baby? |
| • History of emotional/physical/sexual abuse, family violence, childhood neglect | • Can the mother describe the baby's daily routine? |
| • Past pregnancy loss or excess pregnancy concern | • Is the mother able to reflect on the baby's needs? |
| • Unplanned or unwanted pregnancy | • Does the mother express empathy for the baby? |
| • Did the mother receive a prenatal diagnosis of fetal anomaly? | • Does the mother engage in enjoyable activities with the baby? |
| • Fertility issues or assisted reproduction | • Does the mother play/talk appropriately to the baby? |
| • Did the women experience birth trauma? | • Does she delight in her baby? |
| • Was the mother able to touch the baby on the day of birth? | • Does the baby ever make her feel uncomfortable, unhappy or enraged? |
| • Did the mother have responsibility for infant care during the first week of life? | • Is the mother excessively worried about the baby? |
| • Who is involved in the baby's care? | • Does the mother cope with the baby's distress? |
| • Availability of emotional/social/practical support | • Does she respond and attend appropriately to the baby's cues? |
| • How much time does the mother spend away from the baby? | • Are her responses consistent? |
| | • Is she protective of the baby? |
| | • How does she refer to the baby? |
| | • Does she show/share photos of the baby? |
| | • Has she set up a room for the baby? |
| | • Does she buy baby clothes? |

Adapted from Stefan J, Hauck Y, Faulkner D et al (2009).

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| INFANT FACTORS | MATERNAL FACTORS |
|---|---|
| • Is the baby achieving normal developmental milestones? | • Current maternal personality disorder |
| • Is the baby growing adequately? | • Antenatal or postnatal mood disorder |
| • Are there feeding difficulties, reflux, gastric distress, sleep difficulties? | • Psychosis |
| • Does the infant have other health concerns (e.g. eczema, allergies, congenital anomalies)? | • Diagnosed personality disorder |
| **INFANT BEHAVIOUR OF CONCERN** (OBSERVED OR REPORTED) | • Suicidal or homicidal ideation |
| • Gaze avoidance | • Negative symptoms (low motivation, anhedonia, blunted affect, poverty of thought/speech) |
| • Flat affect | • Medication side-effects (e.g. causing sedation) |
| • Lack of crying | • Substance abuse |
| • Limited vocalising | • Engaging in dangerous or risk-taking behaviours (e.g. alcohol or drug misuse) |
| • Emotionally under-responsive | |
| • Interacts too easily with strangers (age dependent) | |
| • Unsettled sleep or feeding | |
| • Difficult to console when distressed | |
| • Irritable, constant crying | |
| • Difficulty separating from parent (age dependent) | |

| PROTECTIVE FACTORS IN THE MOTHER-INFANT INTERACTION | |
|---|---|
| • Mother is sensitive to the baby | • Mother is able to monitor the baby's well-being adequately |
| • Mother is responsive to the baby | • Mother is able to cope with flexibility in her routine |
| • Mother has a close relationship with at least one other adult | • Mother is thoughtful about what might be going on in the baby's mind |

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## Risk to the infant

If there are observed difficulties with the mother-infant interaction and/or if the woman has a significant mental health condition, further assessment is required. Risk of harm to the infant can be related to suicide risk in the mother but can also be a separate issue. It should be noted that expressions of fear of harming the baby may be a sign of anxiety rather than intent, but these should always be assessed further.

Assessment of risk to the infant needs to be conducted with sensitivity to avoid implicitly blaming or stigmatising the mother for having negative thoughts about her infant which could impact the therapeutic relationship.

The way in which risk to the fetus or infant is assessed depends on the setting and the extent of the therapeutic relationship. The following are examples of questions that could be asked, taken from the Postpartum Bonding Questionnaire (Brockington et al 2006) and adapted to the perinatal context.

- Have you felt irritated by being pregnant or by your baby?
- Have you had significant regrets about becoming pregnant or having the baby?
- Does the baby feel like it's not yours at times?
- Have you wanted to harm your unborn child or shake or slap your baby?
- Have you ever harmed your baby?

Action will depend on the answers to these questions. It is preferable that the mother and infant remain together but, if there is a perceived risk of harm to the infant, involvement of others (e.g. co-parent) in caring for the infant or alternative arrangements are advisable.

Notification to the relevant child protection agency may be necessary. All health professionals should be familiar with the legislation concerning reporting of concerns about children at risk of harm from abuse or neglect in their State or Territory. Health services and child and maternal agencies will generally have internal policies setting out these requirements.

## Risk of suicide[2]

Suicide risk assessment requires clinical judgement, a sense of the woman in context, understanding of the baby/infant as both a protective factor and a risk factor, and awareness of how mental health symptoms might affect impulsivity.

### Assessing the risk of suicide

Assessment of risk involves asking about the extent of suicidal thoughts and planning, including:

- *suicidal thoughts* – if a woman has suicidal thoughts, how frequent and persistent are they?
- *plan* – if the woman has a plan, how detailed and feasible is it?
- *lethality* – if the woman has a plan, how lethal is it?
- *means* – does the woman have the means to carry out the method?

Consideration should also be given to:

- risk and protective factors
- mental state – hopelessness, despair, psychosis, agitation, shame, anger, guilt, impulsivity
- history of suicidal behaviour
- family history of suicidal behaviour
- substance use – current misuse of alcohol or other drugs
- strengths and supports – availability, willingness and capacity of supports.

Whenever assessing a woman for risk of suicide, enquiry should be made about her capacity to care for the infant and any thoughts of harm to the infant.


1. Stefan J, Hauck Y, Faulkner D et al (2009) *Healthy Mother-infant Relationship: Assessment of Risk in Mothers with Serious Mental Illness*. North Metropolitan Area Health Service, Mental Health, WA Department of Health.
2. Australian National Suicide Prevention Strategy (NSPS) website - www.livingisforeveryone.com.au



COPE Centre of Perinatal Excellence

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