CHAPTER
3

Perinatal Anxiety and Depression

Issues, Outcomes and Interventions

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The transition to parenthood, especially with the first child, is stressful physiologically, psychologically and socially. As with all developmental stages, the opportunity exists to grow and mature, but there is always the attendant threat of things going wrong, with physical or psychological disability as temporary or permanent outcome. Psychologically resilient people will use the challenges of this transition to review and appropriately modify their coping strategies and their relationships with others, even if all does not go according to plan.

Contrary to previous thinking on this subject, pregnancy does not protect women against distress, mental illness or suicide. Depression and anxiety are prevalent in women of reproductive age and are therefore common during perinatal times. The problems can predate conception and then continue into pregnancy, or start 'de novo' at any time after conception, childbirth or through the postnatal period. Some women (and men) are more vulnerable because of prior adversity in childhood or subsequent abuse, neglect, trauma, separation, grief and loss, poverty, illness and obstetric complications including infertility (Matthey et al., 2004). For other expectant or new parents, anxiety and depres-

sion are already longstanding companions, and this important life event may precipitate further difficulties (Cohen et al., 2006).

Disturbances that do not meet full clinical criteria for mental illness can be associated with adverse outcomes, as can more severe forms of mental illness (Cohen & Nonacs, 2005). Significant anxiety and depression will be found in around 15% of women pre- and postnatally, with higher rates in disadvantaged populations (Bennett, Einarson, Taddio, Koren, & Einarson, 2004; Gavin et al., 2005). It has been reported that the risk of illness onset is raised two- or three-fold in the early weeks postpartum and the risk is higher if there is any previous history of mental illness in the woman or her family (Cox, Murray, & Chapman, 1993). This constitutes the time of greatest risk of psychiatric hospitalisation, with an increase of 16-fold or more in the risk of psychotic illness (Kendell, Chalmers, & Platz, 1987).

Anxiety and depression in the perinatal stage thus have profound importance because of their frequency, potential severity, and long-term problem outcomes for the woman, her infant and the family. Outcomes for mother, foetus, and infant will be influenced by the balance of risk and protective factors present in the individual case along with the availability, access, uptake and response to interventions. In this chapter, we will review these issues and consider routine assessment or screening, and potential interventions.

Routine Perinatal Mental Health Assessment

Evidence indicates that many women fail to identify themselves as depressed or to seek help (Murray, Woolgar, Murray, & Cooper, 2003). Sadly, not all health-care providers will identify their condition. As most women will access obstetric, midwifery, nursing or paediatric care during pregnancy or postnatally, an ideal opportunity exists to ensure that mental as well as physical health is optimised.

There has been considerable debate regarding the best method for routine assessment to ensure reliable identification of illness or subclinical problems and a number of self-report measures have been reviewed by Muzik et al. (2000). The Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) is the most widely used brief self-report measure of maternal distress and depressive symptomatology. It has also been validated for use antenatally (Murray & Cox, 1990) and in men (Matthey, Barnett, Howie, & Kavanagh, 2003). It has been translated into a number of different languages and validated across a range of cultures (Cox & Holden, 2003). As the scale

includes several anxiety-related items, it has recently been argued that it also identifies anxiety.

Formal clinical or structured diagnostic interviews for anxiety and depressive disorders exist, such as the Composite International Diagnostic Interview (CIDI; Robins et al., 1988), but these are not appropriate for routine, universal screening or assessment in everyday clinical settings. They are indicated at the next level (usually postreferral) when accurate psychiatric diagnosis is required.

Self-report measures such as the EPDS are not diagnostic tools. Studies of concurrent validity comparing EPDS scores with results on structured diagnostic interviews do show that there is an increased probability of clinical levels of depression if scores are significantly elevated (e.g., above 12 in English-speaking populations). Nevertheless, scores can also be raised on the EPDS due to transient stress, or grief reactions, as well as anxiety disorders and depression. For community screening purposes it is usually recommended that a lower threshold (over 9) be used to ensure problems are not missed. Further exploration and, if necessary, repeat administration, are recommended to establish the nature of the difficulties and whether further action or referral to a mental health professional is required (Austin & Priest, 2005). Scores over 20 indicate complex histories often involving multiple stressors, including prior traumatic experiences, and any score on item 10 (thoughts of self-harm) requires further assessment. Downloadable versions and many translations are available.

Some models for perinatal assessment also include questions about presence of psychosocial risk factors known to be associated with perinatal mood disorders and difficulties in coping with the adjustment to parenthood (ACOG, 1999). Examples include the Integrated Perinatal Care Program (Barnett, Glossop, Matthey & Stewart, 2005), the Antenatal Psychosocial Health Assessment Form (ALPHA; Carroll et al., 2005), the National Postnatal Depression Program in Australia (Buist et al., 2007), and the Psychosocial Risk Assessment Model (Priest, Austin, Barnett, & Buist, 2008). These can be used alongside symptom-based measures and have potential to identify women at psychological or social risk. Such approaches are not without their critics and further validation studies are needed before it can be established whether early identification reduces incidence or prevalence of perinatal disorders or parenting difficulties and increases uptake of relevant services (Armstrong & Small, 2007; Carroll et al., 2005).

Anxiety and Depression in Pregnancy

Incidence of Antenatal Depression and Anxiety

Studies reporting prevalence rates for antenatal distress and depression indicate that these are comparable with postnatal rates (Golding, Pembrey, & Jones, 2001). Relapse rates for women with a pre-pregnancy history of major depression are high. Cohen et al. (2006) reported a study of 201 women with recurrent major depression followed through pregnancy. Among these 68% relapsed after discontinuation of medication while 22% relapsed despite continuation of medication. Over 60% resumed medication later in their pregnancy. Among women who discontinue mood stabiliser medication for bipolar disorder, 50% will develop an episode in pregnancy (Viguera et al., 2000). Anxiety disorders in pregnancy are as common as depressive disorders and around 40% of women with anxiety disorder present in pregnancy go on to develop postnatal depression (Matthey et al., 2003).

Risks

Compromised maternal mental health poses direct and indirect risks for the foetus and infant. A woman experiencing distress may:

- not attend for appropriate obstetric care
- not monitor her own health and nutritional status appropriately
- be unable to sleep
- be reckless, self-harming or even suicidal
- resort to using cigarettes, alcohol and other drugs to relieve stress
- be the victim of violence from a stressed partner
- be less able to relate positively to her foetus and infant
- be less likely to breast-feed
- have other children who are affected and their distress may elicit hostility.

Effects on the Foetus

Recent research indicates that early patterns of infant social–emotional responses begin developing in utero in response to innate genetic influences and the biochemistry of the intrauterine environment, in addition to being affected by later social and environmental influences (Huizink, Mulder, & Buitelaar, 2004). The precise nature of the impact of stressors upon the foetus and infant will vary depending on the nature, severity, timing and persistence of the stressors and degree of innate resilience (Yehuda et al., 2005). Women

who suffer from stress in pregnancy are more likely to smoke, or use drugs or alcohol to manage their stress. The physical effects of such substance use are well known, while evidence for adverse psychological outcomes for offspring of women who smoke in pregnancy has been recently reviewed by Button, Maughan and McGuffin (2007).

Alder, Fink, Bitzer, Hösli and Holzgreve (2007), in a review of the literature, suggest that higher levels of depression and anxiety symptoms contribute independently of other biomedical risk factors to adverse obstetric, foetal and neonatal outcomes. Those authors note that most studies referred to subclinical levels of symptomatology associated with obstetric complications, pregnancy symptoms, preterm labour and requirement for pain relief. In this context subclinical should not be considered to mean insignificant and it might well be concluded that outcomes associated with a clinically diagnosed disorder or illness may be even more problematic. In other studies, lower birth weights have been found among infants of depressed versus nondepressed mothers in Asian countries (Harpham, Huttly, DeSilva, & Abramsky, 2005; Patel, Rahman, Jacob, & Hughes, 2004).

The work of O'Connor, Heron, Golding, Beveridge and Glover (2002) indicates that elevated levels of maternal stress during pregnancy that are likely to be genetically and/or biochemically mediated contribute to adverse infant and young child behavioural outcomes. One of the mechanisms proposed to account for transfer of stress from the mother to the foetus involves the functioning of the hypothalamic pituitary adrenal axis (HPA), which regulates the neuroendocrine response to stress. Studies have demonstrated that excess activation during pregnancy may interfere with the development of the foetal HPA axis and can lead to a chronically heightened stress response throughout life, altered immune response, anxiety disorders, and possibly other forms of psychopathology (Huizink et al., 2004; Yehuda et al., 2005)

Postnatal Anxiety and Depression

Incidence

Postnatal mood disorders are commonly described as falling into three main categories: the 'blues', postnatal depression, and postpartum psychosis, with rates of 50–80%, 10–15%, and 0.2% respectively. A range of postnatal anxiety disorders have been described, including generalised anxiety, phobias, obsessive compulsive disorder and posttraumatic stress disorder (Brockington, Macdonald, & Wainscott, 2006a; Rogal et al, 2007). Comorbidity is common,

with Brockington et al. (2006a) reporting that 27% of women diagnosed with postnatal depression had two or more comorbid disorders.

The 'Blues'

The 'blues', common enough to be regarded as probably normative, are medically significant only in drawing attention to the likelihood of actual illness ensuing if the symptoms persist or are severe (Henshaw, Foreman, & Cox, 2004).

Puerperal Psychoses

At the other end of the spectrum, postpartum psychosis (affective or schizo-affective) constitutes a psychiatric emergency. Illness is often florid, acute, with onset in the first three weeks postpartum if not prior to the birth, and carries a high risk for the survival of mother and infant. Others may have to assist with care of the infant, and breastfeeding is often difficult to sustain, so lithium, other mood stabilisers, antipsychotic medication and electroconvulsive therapy (ECT) can be used in the usual way. Hospital admission, preferably to a dedicated mother–baby unit, is often necessary (see Chapter 15). With post-partum psychosis a recurrence rate of 50% to 90% is expected with subsequent pregnancies, while some women will also experience episodes at nonpregnant times (Viguera, Cohen, Nonacs, & Baldessarina, 2005).

Postnatal Depression

Postpartum depression (PND), minor or major without psychotic symptoms, may have an insidious onset over the early weeks and months, with the usual features of depressive disorder recognisable if an effort is made to identify them — for example, low mood, anhedonia, inability to concentrate, forgetfulness, low energy, insomnia, loss of interest and appetite, and thoughts of death (self and others). Irritable mood may be a prominent feature. This constellation, allied with extreme fatigue and the additional responsibilities for a new baby, can create difficulties in all the woman's close relationships and in her capacity to care for her baby. Timely identification of any problems and appropriate intervention are thus critical to the wellbeing of the whole family.

Previous studies of women admitted to a residential unit to address persistent 'mothercraft' problems reported that some 40% scored above the threshold for likely major depressive disorder, and a more recent study (Phillips, Sharpe, & Matthey, 2007) confirmed that there are high levels of psychiatric morbidity (depressive and anxiety disorders with a high level of comorbidity) among such clients. The authors emphasised the need for multifaceted interventions to address psychological issues for both mother and

infant. Women with depression are not a homogenous group and it is important to note that not all parents experiencing anxiety and depression show impaired parenting skills, and that not all suboptimal care-giving is linked with parental mental illness (Brockington, Aucamp, & Fraser, 2006b).

Effects of PND on Infants

Payne (2007) has recently summarised the effects of PND and notes that postpartum maternal depression is reported to have adverse consequences for infants and children, including impaired bonding and attachment, impaired emotional, speech, language, and cognitive development, with subsequent behavioural problems. Mitigating factors include availability of alternate care-givers, maternal attachment status and maternal resilience (McMahon, Barnett, Kowalenko, & Tennant, 2005).

Adaptive brain development, including buffering of stress responses, is promoted by secure attachment based around sharing of positive emotional states, regulation of arousal and attunement between mother and infant. Some parenting and attachment behaviours also appear to be programmed at a neurobehavioural level (Cozolino, 2006; Swain, Lorberbaum, Kose, & Strathearn, 2007; Tronick, 2007). Much of the evidence for the impact of postnatal disorders on infant behaviour has centred on exposures to maternal postnatal depression, rather than anxiety disorders or other forms of mental illness (Murray & Cooper, 1997; Weinberg & Tronick, 1998), although we know that these problems often coexist. The timing, severity and duration of the maternal depression will have bearing on the outcomes.

Mechanisms proposed to account for the adverse effects of maternal anxiety and depression upon infants and young children include altered patterns of care-giving and suboptimal parenting behaviours (Milgrom, Ericksen, McCarthy, & Gemmill, 2006; Moehler, Brunner, Wiebel, Reck, & Resch, 2006). Various studies have confirmed that maternal depression impacts on infant nutritional status and health (Harpham et al., 2005; Patel et al., 2004; Rahman, Iqbal, Bunn, Lovel, & Harrington, 2004). Henderson, Evans, Stratton, Priest and Hagan (2003) found that depressed mothers had significantly reduced rates of uptake and continuation of breastfeeding compared with non-depressed mothers.

Interventions

General Considerations

A broad range of interventions for perinatal anxiety and depression have been reported, including psychological approaches, medications and complementary therapies. Anticipation, quality health care and adequate social support underpin all other management strategies offered, along with precise diagnosis and targeted interventions. Research findings from intervention studies have been mixed, and the research is of variable methodological quality. As pathways leading to perinatal disorders are heterogeneous, it is clear that one type of treatment does not fit all situations. More research that identifies which methods work best in different contexts is urgently required (Dennis, 2005; Lumley, Austin, & Mitchell, 2004; Priest, Henderson, Evans, & Hagan, 2003; Rahman, 2007).

Accurate history-taking and diagnosis followed by collaborative treatment approaches will aid in the selection of treatments and improve outcomes. In general, however, nonmedication interventions of proven efficacy for anxiety and depression in general populations are likely to be a reasonable guide to treatments for pregnant and lactating women. Psychotherapy (such as cognitive–behavioural [CBT], interpersonal) should be considered and offered individually or in groups in combination with the addition of medication if necessary and appropriate. Interventions should include attention to the mother–infant and other close relationships for best results (Milgrom, Negri, Gemmill, McNeil, & Martin, 2005).

Community-based care, where mental health services are integrated into collaborative, multidisciplinary approaches offered in one setting, are being promoted to address perinatal mental health issues (Lyons-Ruth, Wolfe, & Lyubchik, 2000). Collaborative approaches to management ideally consider and understand the woman's context as well as her individual strengths and vulnerabilities. It is vital to appreciate her need to understand and remain informed about the broad array of treatment options for emotional distress and difficulties in coping. Continuity of care and carer is an important and fundamental aspect of provision of care.

When depression or anxiety disorders are diagnosed, treatment requires:

- weighing of the risks and benefits
- discussing the availability and cost of the various modes
- determining the acceptability to the woman, and ideally her partner, of what is accessible.

Nonmedication Treatments

Studies demonstrating benefits are varied and include increased social support and nursing care with nurse home-visiting among high-risk populations (Shaw, Levitt, Wong, & Kaczorowski, 2006).

Various types of psychotherapies provided for individuals or groups have been used with efficacy mainly with women with postnatal depression (Murray, Cooper, Wilson, & Romaniuk, 2003b), including:

- supportive methods (Holden, Sagovsky, & Cox, 1989)
- cognitive–behavioural approaches (Milgrom et al., 2005)
- interpersonal psychotherapy (IPT; O'Hara, Stuart, Gorman, & Wenzel, 2000)
- other psychodynamic approaches (Newman & Mares, 2007).

Studies showing promise but needing further research (Freeman, 2007) include:

- increased levels of exercise for mothers
- bright light therapy
- omega-3 fatty acid use
- massage for mothers and for infants.

Involvement of partners in care has proven beneficial in a number of studies and partners are often also in distress (see Ballard, Chapter 7; Fisher, Feekery, & Rowe-Murray, 2002; Matthey, Barnett, Kavanagh, & Howie, 2001). Research into men with depression indicates that they tend to underreport distress, and often have different symptom patterns and reactions from women. In men with depressed partners, rates of depression are increased, although timing of onset of symptoms is later. Matthey et al. (2003) found that one in ten men met criteria for caseness when their partners were affected and when a father was depressed the partner was 2 to 3 times more likely to be symptomatic.

Thus no one psychological treatment approach is preferred, and intervention is likely to be chosen on the basis of patient choice combined with therapist skill level and availability.

Medication

A number of general principles are relevant when considering the use of medications during pregnancy and postpartum for treatment of anxiety and depression and these have been summarised in Table 1. It is important to check what other remedies the woman may be prescribing for herself and to avoid polypharmacy. As always, it is important to explain the situation to the partner, promote good communication and enlist their aid, to the extent that this can be provided. Medications may be indicated in combination with other forms of

Table 1

General Principles in Use of Medication for Perinatal Anxiety and Depression

- Medication should be avoided where possible, especially during the first trimester; however alternative, nondrug treatments need to be considered where available and untreated anxiety and depression also pose risks.
  - All the risks from exposure to *either* medication *or* illness are not yet known.
  - All medication crosses the placenta and also appears in breast milk — to varying degrees
- Following consultation among health professionals and consultation with the woman and her partner, agreed, written, care plans should be drawn up and available to all concerned.
- If conception occurs unexpectedly, medication *should not* be withdrawn abruptly and medical guidance is indicated.
- If medication is used, an effective dose should be prescribed:
  - most antidepressants are also effective for anxiety
  - polypharmacy should be avoided, also bearing in mind that patients may be self-medicating
  - medication that has previously been effective in that patient should usually be first choice
- Careful monitoring is essential:
  - mood stabilising drugs require close obstetric monitoring and adequate folate supplementation
  - pharmacokinetics can change over the pregnancy and doses may need to be changed
  - similar principles apply when using atypical antipsychotic drugs
- With a history of previous severe postnatal anxiety disorder, depression or psychosis, plan for prophylaxis in late pregnancy or immediately postpartum:
  - exposure is generally higher through placental passage than through breast milk so medication used during pregnancy should be the one continued postpartum
  - the infant should be clinically monitored subsequently
- Neonatal adaptation problems are common, though rarely severe, in healthy infants of women on antidepressant medication:
  - since reduction or withdrawal of medication prior to delivery is not always possible or advisable, the infants should be closely monitored for 3 to 7 days postpartum
- Information changes rapidly in this field and up-to-date information must be obtained from relevant hospital helplines or websites such as www.motherrisk.org; www.otispregnancy.org

therapies, as outlined above, and sometimes in conjunction with ECT (Ramos, Oraichi, Rey, Blais, & Berard, 2007). Severe mental illness is best treated in a specialist inpatient mother–infant unit, but this is rarely available. With reliable, 24-hour family support, even severe illness can sometimes be treated at home.

Treatment selection is influenced by a range of considerations that must be carefully weighed, including severity of symptoms, past history of depression and effective treatments, family history of illness and response to treatments, likelihood of compliance, suicide risk, risks to the infant, parental concerns regarding medication, and the baby; as well as financial or time constraints. Since depression itself can have direct and indirect adverse effects upon the woman and foetus or baby, there is not a 'no risk' option.

Self-reports about ceasing or taking medication, dosages and associated self-prescribed drug use contribute to unreliability of information in this emotionally charged setting. For obvious reasons, rigorously controlled double-blind clinical trials of many interventions have not been conducted, although there is a considerable body of clinical evidence about merits and problems of specific medications when used in pregnancy or postnatally. Information concerning the safety of medication is altering rapidly and prescribers would be well advised to become familiar with reliable websites and always seek contemporaneous information.

In Pregnancy

Chambers, Moses-Kolko and Wisner (2007) provide a recent review of medication usage in pregnancy. With the caveats in the previous paragraph, reported adverse effects of antidepressants (tricyclics, selective serotonin reuptake inhibitors, mirtazapine) in pregnancy include higher rates of miscarriage and preterm birth, but not of major malformations. Nevertheless, some studies recommend avoiding paroxetine and doxepin (Oberlander, Warburton, Misri, Aghajanian, & Hertzman, 2006), and recent research reports small increases in birth defects with many selective serotonin reuptake inhibitors (SSRIs) (Alwan, Reefhuis, Rasmassen, Olney, & Friedman, 2007; Louik, Lin, Werler, Hernández-Diaz, & Mitchell, 2007). Some current views on SSRI usage in pregnancy have been recently summarised by Cohen (2006), who states that 'there are more reproductive safety data available for SSRIs than for many medicines women take during pregnancy' (p. 12). A 'serotonin syndrome' (toxicity) and a 'neonatal abstinence (withdrawal) syndrome' with symptoms such as jitteriness, sleep disturbance, dysregulation, respiratory distress, irritability, lethargy, myoclonus and tremors, have been reported; also an elevated risk for severe respiratory failure — persistent pulmonary hypertension — where SSRIs have been used during the third trimester.

Raised levels of anxiety are to be anticipated during pregnancy, a venture where the outcome can never be guaranteed. Benzodiazepines are problematic as a treatment for anxiety in women at any time in their lives, and may add further risks for the foetus and breastfed infant. It had been suggested that benzodiazepines should be avoided during the first trimester as they might be teratogenic (e.g., resulting in cleft palate), but this finding has not been supported by later studies. Short-acting single doses may be acceptable later in pregnancy, but not in addition to other psychotropic drugs. Neonatal sedation is likely, especially if these drugs are used intramuscularly or intravenously before birth. Various neonatal problems have been described and include: Floppy Baby Syndrome, Neonatal Withdrawal Syndrome, including respiratory depression, jitteriness, and seizures (Moses-Kolko et al., 2005).

Mood-stabilising medication, such as lithium or anticonvulsants, is problematic during pregnancy. Folate supplements and careful monitoring of mother and foetus will be required. Collaboration with a specialist team is recommended (see Chapter 15).

Postpartum

Psychotropic medication is often avoided by women and their medical practitioners during lactation, as well as during pregnancy. Payne (2007) notes that studies support the use of tricyclic antidepressants, sertraline, paroxetine, bupropion, venlafaxine, fluvoxamine, and omega-3 fatty acids in the treatment of postpartum depression where the mother is not breastfeeding, but that breastfeeding mandates caution with medication. Problems similar to the toxicity and withdrawal syndromes described immediately after the birth, including (rarely) seizures, have been reported in infants breastfed by mothers on SSRIs. Both perinatally and postnatally, it can be difficult to differentiate withdrawal from toxicity. Caution has been advised when considering fluoxetine and citalopram (in high dosage) during lactation (Eberhard-Gran, Eskild, & Opjordsmoen, 2006) although in general terms, very little psychotropic medication per body weight is transferred in breast milk.

Depressed or Anxious Babies

Although most clinicians are aware of the signs and symptoms that may occur in depressed adults, fewer are aware that children and infants also suffer from this problem. The signs and symptoms are fundamentally the same, but expressed in age-appropriate fashion. That is, on careful observation and enquiry, one can expect to note developmentally appropriate expression of low

mood, anhedonia, subdued affect, misery, crying, irritability, low energy levels, apathy, and appetite, weight and sleeping problems. The baby will not be happy, playful, willing to engage, interested in the caregivers and environment, gaining weight, trying to communicate, settling contentedly into a routine.

Case Studies

A. Freda was a 28-year-old woman who sought antenatal care from her general practitioner (GP) when 16 weeks pregnant with her first baby. She was concerned about recurrence of the depression she suffered in her first year at university. At that time, after refusing medication for many months, Freda had finally recovered spontaneously, but she remembered how awful the experience was. Since conceiving, she had been reading about postnatal depression on various websites.

   At consultation, it was clear that Freda was not currently depressed but apprehensive and wishing to do everything she could to avoid an episode occurring. Her EPDS total score was 7 and she scored 0 on question 10, indicating the absence of thoughts of self-harm. The GP discussed the various management possibilities with her and commended her wish to do all that she could to become more resilient. They agreed on a plan that included fortnightly monitoring visits to the GP, a careful exercise and dietary regime, with anticipatory arrangements about how the early weeks and months of parenting would be managed by the couple, and some self-help CBT from one of the websites.

   After guidance about the difference between birthing classes and parenting classes, Freda decided to attend the latter with her partner. Should medication be required, this would be gradually introduced. The plan was designed to enhance her coping skills and confidence, while ensuring that any onset of depressive illness would be quickly treated. All went well and Freda, despite a shaky start after a difficult labour, settled into her new role satisfactorily, managing to breastfeed for six months before returning to part-time work.

B. Amelia was a 34-year-old woman, referred by the Child and Family Health Nurse (CFHN) to her GP at 4 weeks postpartum because of possible postnatal depression. She had an EPDS score of 15, with 0 on Question 10, and was having panic attacks during the afternoon and early morning on most days. She believed she had not recovered from 'the baby blues', was miserable, irritable and could not sleep, even when the baby did. She was terrified something was going to happen to the baby or her husband. Amelia had no

appetite herself and had given up trying to breastfeed Ben, having decided she was never going to be a good mother.

This was Amelia's first baby and he was very much wanted. The couple had been trying to conceive for many years, including eight cycles of in-vitro fertilisation (IVF), and Benjamin was conceived to their surprise after they decided to have a break from the treatment. There was no clear personal history of mental illness, although Amelia had always been an anxious, conscientious person — like her own mother, who suffered several episodes of depression and was finally treated successfully with medication. Amelia was dismayed to think she might be repeating her mother's history — remembering well what it had been like in the house when her mother became agitated or subsequently retired to bed, seemingly for weeks on end.

Information about anxiety, depression and the vicissitudes of mothering were offered to the couple and antidepressant medication was recommended. As Amelia did not wish to try and resume breastfeeding, she was willing to take the medication (sertraline). Her husband was very supportive once he knew not only why he had suddenly become the target for her irritability and misery, but also how he could help in practical ways. Amelia responded well to her antidepressant medication and attended a group for depressed new mothers, finding it very helpful and making some long-term friends into the bargain. When she had recovered from her depressive episode, Amelia was referred by the GP to a psychologist for a course of CBT, aimed at providing her with more adaptive strategies to deal with her chronic anxiety.

Meanwhile the CFHN had been visiting to provide information about infant development and enhance the mother–infant interaction. The nurse noted that Amelia's anxiety tended to make her oscillate between intrusiveness and avoidance, responding more to her own anxiety than to her infant's cues. Her infant was noted to avoid eye contact with his mother. After discussion with the GP, Amelia was referred to a mother–infant group run by a local clinical psychologist, where she learned to sit back, observe attentively and understand her infant and his communication (Cohen, Muir, & Lojkasek, 2003).

Conclusions

Always provide information and discuss options with the woman, and her partner whenever possible, especially where there is a history of mental illness.

- Understand relevant psychosocial risk factors that predispose women to difficulties in coping during the perinatal period in order to detect women at risk who may benefit from referral for additional supports.
- Anticipate difficulties, where possible, through careful history-taking and timely family planning.
- Offer biopsychosocial care and teamwork, link to relevant services, include psychiatric care where history indicates.
- Learn to use a simple self-report tool such as the Edinburgh Postnatal Depression Scale which can be downloaded from various websites (see below)
- Obtain information, support for the woman, her family, and for yourself, identifying available resources — professional and other. Websites such as: http://www.motherisk.org, http://www.otispregnancy.org, http://www.beyondblue.org.au, http://www.blackdoginstitute.org.au provide useful, up-to-date information in this dynamic field.

Useful websites

http://www.beyondblue.org.au
http://www.blackdoginstitute.org.au
http://www.motherisk.org
http://www.otispregnancy.org

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