

themselves within three months.⁶ If a woman gives up smoking by the 16th week of pregnancy, her risk of delivering a low-weight baby is similar to that of a non-smoker.⁷

The fear of gaining weight is often mentioned as an important issue for women smokers. In one survey, 25 per cent of women stated that a fear of gaining weight was a major factor discouraging them from quitting (twice the proportion of men).⁴ Weight gain may occur after quitting because of the absence of nicotine, which suppresses appetite and increases a person's metabolic rate. However, only 14 per cent of both male and female quitters report weight gain as a disadvantage once they have stopped smoking.⁴ Other research indicates that the average weight gain is about 2.3 kg.⁷

Cessation advice for women should address their specific concerns. For some women, this may involve providing advice on making their home smoke-free and reducing exposure of children to passive smoking. For those who smoke 10 or more cigarettes a day, nicotine replacement therapy doubles a smoker's chance of a successful attempt to quit. Some women may seek advice and support during pregnancy, while many others, especially those concerned about gaining weight, could benefit from complementary advice about nutrition, exercise and stress management as part of a smoking cessation intervention.

Advice on quitting smoking is available from the Quitline on 131 848 or the NSW Quit Campaign on 9818 0450.

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POSTNATAL DEPRESSION

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Up to 15 per cent of women suffer from an episode of depression in the first six months following childbirth.¹ Postnatal depression is no different symptomatically from depression that arises at other times in the life cycle; its uniqueness and importance lies in its close association with childbirth and the predicability of it emerging after childbirth.²

The causes of postnatal depression are predominantly psychosocial, with little evidence to support a hormonal cause.¹ The physiological and emotional stresses associated with childbirth, and the role and identity changes a woman experiences along with the stress associated with caring for a new infant, act as the precipitant to depression among vulnerable individuals.

The key risk factors for women are: poor social support, particularly lack of emotional and, to a lesser extent, practical support from partners in caring for their babies;³ lack of other sources of practical support; having an anxious personality; and obstetric factors such as early discharge from hospital,⁴ a traumatic delivery or caesarean section.⁵

Recent research has found that postnatal depression has a profound impact on the healthy development of an infant. Infants of mothers suffering from postnatal depression may have impaired cognitive development and difficulty in forming attachments. The long-term sequelae of such developmental difficulties have not been researched; however, it is speculated that they contribute to the development of such common psychiatric disorders as depression, anxiety, and drug and alcohol problems. Postnatal depression may also be the first episode in a life-long pattern of recurrent depression for some women, and early intervention may prevent this from occurring.

Finally, postnatal depression may also have adverse consequences for the woman's relationship with her partner, leading to relationship breakdown and all its attendant social consequences.

These detrimental outcomes of postnatal depression highlight the importance for early recognition and treatment of the disorder. It is now well recognised that the majority of instances of postnatal depression are not diagnosed or treated. One method of increasing the recognition of postnatal depression is to use a screening tool for the disorder. A proposed tool, the Edinburgh Postnatal Depression Scale,⁶ has been developed to be used for such screening. This user-friendly, 10-item scale can be completed by a woman in a few minutes. A score of 12 or more suggests a high probability that a woman is suffering from major depression. In an Australian study, we found that women who scored greater than 12 met diagnostic criteria for major depression (sensitivity = 100 per cent, specificity = 95.7 per cent, positive predictive value = 0.69, likelihood ratio = 23.1).⁷ Such a screening tool could be used routinely in early childhood clinics or when a woman attends her postnatal check-up at six to eight weeks postpartum. While women at high risk of developing postnatal depression may be targeted (for example, those lacking social support) screening in all populations is appropriate.

Although many women with postnatal depression will respond to specific but simple counselling in a primary health care setting,⁸ some may need to be referred to specialist mental health services, particularly when the depression is complex or there is risk to the infant. Consequently, screening needs to be supported by appropriate referral for treatment.

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