Presidenza del Consiglio dei Ministri

NATIONAL BIOETHICS COMMITTEE

ASSISTANCE TO PREGNANT WOMEN AND POST-PARTUM DEPRESSION

16th of December 2005

CONTENTS

PRESENTATION

In the early summer of the year 2002, in the wake of the dramatic news stories, which had deeply perturbed Italian public opinion, the *National Bioethics Committee* decided to deal with and examine in depth the complex issue of *post-partum* depression, in order to remain faithful to the commitment to continue to promote two bioethical principles that have always been precious to the Committee: namely, recognition of the equal importance of mental health and physical health (this principle had been recognized and shared by the Committee from its very first documents) and the very special bioethical attention that is to be given to women in all the circumstances in which, unfortunately, (due to physical, psychological or social reasons) she may manifest her identity as a *weak subject*. Inspiration regarding reflection on the issue was provided by Prof. Renata Gaddini, who was unanimously asked to develop the first guidelines on this topic. Moreover, at the plenary session on September 19th 2002, there was a lively discussion concerning the advisability of prefacing the discussion on *post-partum* depression with – what many members of the Committee considered as equally important and some even logically considered as a priority – a reflection on *assistance to pregnant women*, as being the central bioethical theme, *also* in view of an appropriate *prevention* of depression. It was therefore decided on in that plenary session to give the topic and the consequent task of the Committee the title that it has definitively adopted since then and Professor Luciano Eusebi - one of the most lucid supporters of the opportunity to join together the reflection on assistance to pregnant women and that on *post-partum* depression - was invited, together with Professor Gaddini, to preside over the newly established working group. Profs. Battaglia, Binetti, Coghi, Forleo, Flaminghi, immediately expressed their desire to participate in the work of the group; subsequently, they were joined by other colleagues, namely, Profs. Bompiani, Borgia, Caporale, Casini, Di Pietro, Guidoni, Palazzani.

The working group held its first meeting November 21st 2002, after a subsequent meeting in December of that year, it met five times in 2003, three times in 2004 and four more times in 2005. The group meetings have always been very intense and lively, also due to the fact that there were, from the very beginning, two different lines of reasoning on development of the topic within the group: one that interpreted the issue of assistance to pregnant women as to be connected *exclusively* to the risk of *post-partum* depression, and the other that aimed instead at extending in a complete way the subject of assistance to pregnant women, even in terms of prevention of abortion (according to the explicit provisions of Article. 5 of Law 194 / 1978) and therefore independently from strictly limiting this subject to depression. Very authoritative opinions in the group came forward, for instance, that of Professor Carlo Flamigni, who was contrary to the second option and this stance was largely shared by Prof Gaddini herself. However this line of reasoning remained a minority view within the working group, as indeed it remained a minority when it was reproposed by the writer in the plenary session, which instead confirmed with an overwhelming majority the opportunity to hold together the "two souls" of the document, provided, however,

that they were examined in two distinct sections, coordinated among themselves, but also easily isolated from each other.

All the members of the group collaborated in the drawing up of the draft document, Prof. Eusebi revised it several times, demonstrating his great willingness and patience; Prof. Gaddini prepared for publication the pages that are of particular psychological and psychoanalytical importance; Prof. Coghi effectively revised and supplemented the document, particularly as regards the second part; our special gratitude goes to Prof. Cinzia Caporale, who worked hard to obtain as much convergence as *possible* on the text: proof of the success of her work is given by the very small number of Committee members who could not identify with the pages we are now taking to press.

The draft document prepared by the working group was received by the Committee which met in plenary session on the 15th of July 2005. It took another five sessions (16th of September, 30th of September, 21st of October 18th of November and 16th of December) to complete in-depth discuss –and in some points to radically revise - the draft prepared by the working group. A member of the Committee, Professor Carlo Flamigni, while participating in four of the six plenary sessions dedicated to the subject (more precisely to that the 15th of July, 30th of September, 21st of October and 18th of November 2005), stated his abstention from work on this subject, as he did not agree with the structural layout of the document, [his presence (documented in the minutes) is hereby officially confirmed, seeing as unfortunately a major daily newspaper published a completely unfounded statement, according to which, Prof. Flamigni *had not been informed* or even *notified of what was on the work agenda* of the Committee]; similar doubts were also expressed more than once even by Prof. Mauro Barni.

At the session of the 21st of October 2005 the Committee approved the first part of the document. At the session of the 16th of December 2005, the Committee also approved the second part of the document and carried out a further vote on the document as a whole. Professors. Forleo, Garattini and Schiavone abstained in the voting. Prof. Mauro Barni voted against.

The writer hopes, disagreements aside, which are objectively deemed marginal, that this work evinces the high commitment to bioethics that distinguishes the NBC.

President of the Italian National Bioethics Committee
Prof. Francesco D'Agostino

INTRODUCTION

1. In a previous document entitled "Pregnancy and childbirth from the bioethical standpoint," the NBC highlighted the bioethical issues related to such *vital states* as mother and child, considering them not only worth of the protection relating to health and life, but also of appropriate protection with regard to the psychological and social aspects.

On this basis, the NBC intends, to consider, through this text, the assistance requirements in favor of women in reference to - within the framework of existing legislation - the stages of pregnancy and the *post-partum* stage, emphasizing the bioethical significance involved, in relation to such requirements, in the concreteness of the social and institutional response: that is, even in light of the renewed social interest, perceived for similar stages of life and their relative problems[1].

Particular attention, even on the invitation of the Minister of Health, is dedicated to the subject of mental illness that can occur in the mother, sometimes markedly, during the puerperium, through events ranging from mood changes, to the *blues*, post- partum depression, as far as puerperal psychosis. These are events which, because of the peculiarities of the bond that develops between mother and child through pregnancy, can also have a direct fallout on the life of the latter, as well as, serious tensions as regards the interaction between mother and newborn.

The unitarian approach to the multiple profiles which, for a woman, may be adopted by the assistance linked to the sequence-pregnancy-childbirth-puerperium is proposed therefore to encourage deeper reflection on the overall significance of such a condition – unique in its characteristics – on a woman's life as well as on each human being, so as to help protect it from possible traumatic consequences.

2. Pregnancy constitutes one of the most challenging tests for a woman, given the biological commitment and psychic elaboration that is involved in the event, despite its being confined within defined chronological limits. It also constitutes a test as regards the couple's life project, as its natural maturational evolution.

It is an event which, although it occurs within a precise time, starts from very far off, summing up in itself the incidence of various components, such as the two partners' families of origin, their biological and psychological history, the socio-cultural environment in which they grew up: this event, therefore, takes on a particular complexity and uniqueness, that conduct to many possible fragile points.

Everything in pregnancy occurs through visible changes, not comparable in scope, to those that characterize other periods of transition in a female's life, such as, for example, adolescence and menopause, which unfold over a longer period of time. From a biological point of view the body becomes a laboratory that is activated in an exceptional way to ensure the development of new individual, to carry out a series of adjustments to new needs, to create, among other things, the

[1] Consider, among other things, how our country is representative in Europe, of the lowest rates of birth and for the most advanced average age (30 years) at first birth.

physical space needed for pregnancy itself, through an extremely important transformation of the body.

This intense biological work is matched by a very challenging psychic mobilization, that has to face up to the new reality, but also deal with the reappearance of past conflicts, in a situation of increased permeability between the somatic sphere and the mind, with reverberations and mutual interference between these levels.

The personal structure of the woman is therefore involved at all levels in the experience of pregnancy: on a biological and physical and physiological level, on a psychological and psychodynamic level, but also on a relational and spiritual one.

Pregnancy, in fact, affects all of the relationships experienced by the mother: on the one she has with itself and with her partner, but also on those relating to family, friendships, work; and what is more, above all, it affects the relationship with the child that the mother has *inside*, and not just *in front of* her: the - only – case in which an individual contains within itself another individual; therefore, it is a condition worthy of extra-special attention and support from society, even as the prototype of every intimate relationship or of care.

Pregnancy, due to these aspects, directs to what *goes beyond* sight, touch, and emotional feeling, that is to say, a reality (which could be defined as *mysterial*) that can not be fully possessed, confined or dominated.

Approaching pregnancy, therefore, requires a global approach that takes into account as much as possible the different aspects at stake in order to be able to identify the area for "assistance to the woman" that will experience, is experiencing or has just experienced pregnancy.

Therefore, pregnancy and along with it the puerperium and lactation constitute a sequence of events that are from their very beginning biological, psychological, and relational. Now, while the biological events have for the most part a predictable and relatively homogeneous sequence, psychological and relational events are part of the existential vicissitudes of the person involved, and take shape in this way according to very extensive variability.

In this context, it is usual to consider pregnancy, especially the first pregnancy and pregnancy in its early stages, as a moment of crisis, to refer to the collective changes that occur in conjunction with some nodal events of life. Under the influence of biological and psychological facts that are themselves complementary and interactive, during pregnancy, substantial transformations occur as regards the factors structuring the organization of personality. Pregnancy, therefore, is a critical stage of life, in which psychological development is called on, to some extent, to change direction, which implies a sort of recovery of individual growth: it is, consequently, a phase rich in incalculable evolutionary potential, but which at the same time is open to risks that should not be underestimated.

It is hoped that due psychological attention is also given to these changes, to avoid only hearing about clinically manifest psychiatric disorders and disorders which have already caused serious consequences.

When certain characteristics of personality are present, they can in fact determine such imbalances as regards pregnancy that the above-mentioned crisis profiles take on psychopathological aspects, sometimes with frankly psychotic outcomes, as far as the configurability of so-called puerperal psychosis.

Faced with the need to prevent such phenomena there does not, however, seem to be any benefit, from the tendency which sometimes assumes the contours of a genuine cultural solicitation, towards an exclusively medical approach to pregnancy and motherhood. A similar reductionist perspective, on the other hand, impoverishes the very experience of motherhood and, thus, the woman experiencing it. Even the language betrays this way of thinking, not surprisingly, there is more reference to pregnancy than there is to maternity, to diagnostic protocols to be followed in a binding iter rather than human growth related to, and so on.

There is the tendency to ignore, in this way, the psychological support of the mother and the couple during pregnancy, limiting it only to cases in which the failure now appear obvious.

3. From these premises, the NBC has elaborated two distinct reflections, proposed later in the document: one refers to the assistance to which every woman has a right to during pregnancy, based on an analysis of the problems emerging in the different stages of pregnancy and the training of the young in parenthood, and the other is oriented to analyze, on the basis of a more specific psychological approach, the reasons, the prospects for prevention and treatment options of the various *post-partum* diseases.

ASSISTANCE TO PREGNANT WOMEN

1. The issues related to early stages of pregnancy - The start of pregnancy for the woman opens a time of great emotional tension: on the psychodynamic level it includes processes of maturation towards the achievement of the new role, which recreates the experience of relationship with her mother and causes a re-elaboration, and regression processes, because each new reality causes anxiety and induces to seek reassurance in the way experienced in the past.

The first few weeks are often marked by ambivalent feelings of satisfaction with the child's existence, but also of fear of it, granted that the child imposes itself through the laws of its growth. In this respect, the ambivalence can result in such a widespread malaise as to be considered physiological

During pregnancy, similar ambivalence evolves more clearly with the recognition of the child, giving rise to the assumption of the maternal role. Not always, however, without difficulty: difficulties which would benefit from the availability of psychological support, which should eventually be accessible even to the father.

The stage, under examination, of pregnancy can be described within some time limits and certain generally recognized characteristics:

a) that it begins at the moment of realization of awareness of pregnancy and, therefore, motherhood taking place;

b) the existence of an intrapsychic conflict – related to having to make room in the body, mind, and in one’s life for a child that exists, is growing, and imposes its own pace, needs, and the laws of its development – together with instances of acceptance, always present in the inner structure of female personality, and

instances, found in every individual, of non-acceptance and immediate self-affirmation;

c) its being characterized, therefore, as a phase of transition from ambivalence to inner acceptance of pregnancy, which in this way, psychologically, is taken up by the woman: through the organizing of the mother-child relationship in the coordination of respective identity and needs, the strengthening or the structuring of the couple's relationship faced with the reality of the child, the course of affirmation of her role by the mother herself, accompanied by the recognition of that role by society.

In the case of obstacles and / or emotional difficulties, assistance to the woman during the internalization of pregnancy, therefore, assume the contours of support to the natural evolution.

The problem that involves the voluntary interruption of pregnancy should also be considered in this framework, its ability (de facto or within legally defined limits) changes in many cases the basic psychological dynamics related to the first stage of gestation: for many women, as seems broadly widespread, this stage, is, in fact, consequently to be seen as the time in which willingness or unwillingness to continue the pregnancy is decided.

We find ourselves faced with different aspects of the first stage under review, which should be reflected in the corresponding forms of assistance to the woman.

It follows that material and psychological assistance, empathetic expression of a willingness to support intended to promote a calm approach to gestation, will have to operate for the benefit of every woman who is pregnant, and should not be limited only to situations, or the period of time, where the woman has already been placed in a prospective for its continuation.

It therefore seems necessary to reflect on the activities of counsellors, social workers, hospital obstetric and gynecological services and, in general, physicians who encounter the woman when she realizes she is pregnant. The establishment of the psychological interview and the interview for assistance can not neglect to emphasize the value of *favourable reception* (for the woman, for her child, for the father, for society), showing a positive stance to it.

2. Attention to difficulties – Particular attention should be devoted to analyzing and contrasting the many difficulties that today often seem to hinder the desire to become pregnant, or the opportunity to live the experience in a serene way.

These are among the many issues that seem significant:

a) beyond the situations of conflict, is the transition itself from being a "couple" to being a "parental couple" and "family " which is often now seen as problematic: in many cases the individuals in the relationship appear to limit this horizon, at least for a long period, to being only a couple, showing poor motivation to identifying with the parental aspect;

b) to act as people who contribute to the building of a civil society in the same roles that are accessible to men is an arduous experience for many women and they however, at some time, find fulfillment in motherhood as a potential expression typical of their identity;

c) there comes into play, as well as the existential conditions of women, the difficulties of daily life that according to the model characterize, in our time, social

relations (economic difficulties, concerning the preservation of a certain standard of living, work, management of schedules and time in general, lack of family support services or sufficiently numerous support services that are sufficiently available to respond to actual needs);

d) the aspect of competition takes on a role that can not be overlooked, in an age group that is the most important for professional inclusion, also, to be considered are the problems relating to the guarantee for maintaining employment; nor can one ignore areas of circumvention of the very rules to ensure the freedom of workers to undertake a pregnancy.

In this framework, however, it turns out to be important for a positive attitude to pregnancy to help the woman's development of a mental space for the child, to open up to the possibility to take an active role towards the prospect of pregnancy or to an ongoing pregnancy and the associated imagined plans: a space which is limited, especially, by conflicts with the partner, the family of origin or with personal life projects, by not enough support for *single* mothers, etc.. (whereas constraints arising from practical situations of an economic or logistical nature appear to have a weaker influence).

The need for special training for gynecologists and health professionals, to enable them to understand the various ways in which women face the prospect or reality of a pregnancy emerges from all this. Similar training should be oriented to detecting the possible conflicts with regard to pregnancy, giving ample space to the capacity to listen and to the finding of the conditions for the existence of the mental space for the child.

3. Investigations on the health of the fetus - Another aspect that should be carefully considered with regard to assistance to pregnant women is the availability and a major use of means designed to monitor fetal development and detection of genetic features.

In the perspective of this Document it should be particularly noted, in this context, that research, particularly genetic research, so full of psychological and ethical implications must always be preceded and followed, as also provided in several guidelines, by counselling by a geneticist, obstetrician and pediatrician (while it appears that in 2002 only 20% of the tests were accompanied by genetic counselling). Some reservations regarding the qualitative aspect seem inevitable (consider that only 25% of the Italian Centres have a quality certification).

The danger is that prenatal diagnosis is understood as a business, especially in the context of availability of the test without medical supervision, and does not take due account of the basic problematic issues from the ethical and medical point of view (in particular, of the appropriate use of safe and effective genetic testing to be carried out in laboratories with high standards of quality) and the psychological point of view.

The presence of the geneticist is essential to give adequate information before and after the test, taking particular note that in many cases there may be only probabilistic answers (among other things also limited by the incidence of false positives and false negatives) or that can not provide certainty with regard to the range of severity that a disease may present. It should be noted, in this sense, that the risk of spreading a genetic-tecnological mentality - a cultural drift – which

attributes to genetic data an all-encompassing deterministic role and promotes a social attitude of rejection of the subjects that are considered abnormal, presenting fetal disease as intollerable.

Mostly, the results of these investigations are not mentioned so far, despite being ethically indispensable, as part of a dialogue in which to prepare and facilitate the processing of any bad news and suffering resulting from it. Indeed, it is sometimes considered a mere solicitation for investigation, dependent on considerations of supposed medical self-defense.

The already reported significance of psychological assistance to pregnancy, which contributes to a responsible attitude, therefore, assumes special profiles with regard to the finding of a negative genetic data concerning the fetus, in order to avoid a certain kind of automaticity between specific results of genetic testing and abortion outcomes.

The woman and the couple, in particular, are entitled to know with precision, as part of prenatal diagnostic feedback, not only the clinical data acquired objectively, but also their meaning and also to have adequate information about the resources available as to the favourable reception, education and care of a child with problems identified during pregnancy, as well as being able to count on constant and enduring institutional and human solidarity, this latter requirement, often disregarded.

4. Educational profiles - In addition, there is a call for further attention concerning the formation and guidance of young people in relation to pregnancy.

In particular it should be noted, among the many possible considerations, that there are very common patterns of sexual behavior characterized by a basic common denominator, represented by the a priori separation between sexuality and the prospective of procreation, or more generally between a couple’s life and parenthood.

What often appears absent is the formation for the taking of future responsibility represented by the generation and to a responsible generation. The sense of personal responsibility to which many young people, in this regard, are educated, does not go beyond the level of protection against infection and risk of pregnancy by means of mechanical or chemical contraception.

However, it would be a serious impoverishment to deprive young people of reflection on the opening up to the generation of life, which is the premise of sexuality, as well as information on the recognition of fertility. Consequently, it appears, fundamental to extend the perception of the sense of responsibility of young people with regard to the possible determination of the life of a new individual. Therefore, it can not be satisfactory to have sex education without education to the generation of life.

It would be superficial, for example, to address the problem of underage pregnancies in girls as a problem related to the mere information on contraceptives. Nor would it be satisfying to merely propose support for the possibility of an ongoing pregnancy.

Often young people are encouraged to think, in the case of an early pregnancy, that the solution lies in the non involvement of parents and to pretend that "later", after the interruption of the pregnancy, everything will be like before;

rarely are they helped to analyze the psychological burden of entry to life marked the experience of an abortion.

Of course, it is necessary to reflect on the educational reality of the young woman and young man, from the time of adolescence: it is then, in fact, that the possibility of clear, objective and involving information on pregnancy and its physical and emotional profiles, prenatal development of the child, the human significance of motherhood and fatherhood begins.

Another aspect concerns the importance of formation for favourable reception, designed to avoid the problems linked to the prospect, through having a child, of merely realizing the psychological needs of parents or their too specific expectations. In such a context, in fact, only at first sight this could create a kind of “strengthemed”, granted that any motivation other than that in reference to the very existence of the child itself may make the parents more insecure as regards the difficulties that may arise in future. Although today children are often born in the context of highly motivated choices made in relation to the experiences of the parents, neglect and violence against children does not seem, moreover, significantly on the decrease.

5. Assistance to women faced with the hypothesis of termination of pregnancy - As regards, in particular, assistance to women considering a possible termination of pregnancy it should be noted, first of all, that this hypothesis comes during the stage of ambivalence described above and is therefore refers to a context of particular emotional fragility.

It appears on the other hand, that if the process started at conception is interrupted, albeit voluntarily or even spontaneously, the abovementioned ambivalence there is a lack of constructive elaboration, and the possibility of the production of destabilizing effects.

Pregnancy is not just a physical fact and the relationship with the child is not just physical: in fact, mourning the loss of a child requires elaboration, because the child remains intrapsychically. To confine the pregnancy to a woman's *body* and ignore the intensity of interior involvement which it implies (it is significant we refer to the *desire for pregnancy* and *maternity*), thus forgetting the complexity of the psychodynamics of pregnancy, is likely to induce the woman operation to devalue or deny the emotional and relational reality that she is experiencing.

In addition to the problems inherent to the context of a woman's life, it is therefore necessary to consider, from the point of view of psychological assistance, precisely the relationship of the woman with the reality of pregnancy: evading the issue would mean to not consider the role that it assumes, for the woman herself, the *content* of the decision referred to the possibility of abortion.

Abortion has an objective significance that goes beyond individual "experience" and, therefore, the reality represented by the existence of the unborn child can not be anything less than consistent in the interview.

Working on the inner "experience" of the woman in relation to an unexpected or unwanted pregnancy is especially important when the couple's relationship is problematic. The woman who feels alone when faced with maternity experiences insecurity regarding her abilities, along with the fear of not being able to manage the situation independently. The anguish of not being able to cope psychologically

with the unfavorable environment may prevail over the inner perception of positivity. And this is precisely the moment at which the option of an abortion can occur, this involves, as well as the life of the child, also that of the woman by inhibiting the realization of positive aspects of her identity.

When those to whom the woman turns to for support, even indirectly, do in actual fact, give a negative opinion ("you can't cope"), this assessment could become a very insidious message for the image that the woman structures within herself as regards to her own individual resources: in the research on post-abortion the woman manifests in many cases an increase of contempt, not only in relation to any feelings of guilt, but also in relation to self-judgment ("you weren't able to cope").

The assumption of the principle that pregnancy is a condition that requires specific forms of assistance in favor of women, given the human value of gestation and the commitment that it requires from the expectant mother, is a universally shared fact and is expressed in various legislative texts, including the Law 194/1978, whose title first of all makes reference to the *social protection of maternity.*

In particular, the provisions of art. 5 of that law, which focus on the concept of assistance to be offered to women when they enter the interview, as provided by the aforementioned legislation, should have constituted the unanimously shared social and legal approach to the problem of abortion, but their implementation - according to widely shared opinion- has remained insufficient.

Such provisions, aimed to "*remove the causes that lead [the woman] to the interruption of pregnancy*", move in the direction of a commitment of the socio-sanitary services both to the interests of the woman, and to the interests of the unborn and express, in an case, the *non-indifference* of the legal system as regards the prospect of an interruption of pregnancy. In this way, they fulfill the preventive aim prior to abortion, according to the will expressed by the legislature, through dialogue and assistance (in this regard, special attention is now paid to immigrant women, especially if their presence in Italy is illegal).

It is a direction that must be pursued even if the interview is performed by a doctor (making available to him, among other things, appropriate training and methodological guidance), in order to not miss, even in that case, the opportunities arising from orientation to dialogue and assistance, according to the instructions of the legislation at issue.

It is, in short, a fundamental revaluation of a shared commitment to supporting women in pregnancy, so as to make clear in the context of social and public institutions the existence of a positive climate, a sympathetic approach and solidarity to the ongoing pregnancy, the climate the perceptibility of such a climate often seems rare; and therefore to counteract the effects of discouraging or even blaming the woman who, is preparing to face a pregnancy that is in any way problematic, undertakes a series of responsibilities personally and indirectly for society.

In the same sense, the often asserted logic must be overcome which perceives pregnancy as a sort of intrinsic conflict between the interests of the woman and those of the unborn child: taking into account, among other things, the

impact that an interruption of a pregnancy could have in future on the woman, as attested by many post-abortive experiences.

The implementation of the stated provisions responds moreover, to the legislative choice to request, in the case of possible voluntary interruption of pregnancy, for the woman to relate to the facilities or persons specified by the legal system[2].

In this context, serious planning of the way in which the interview, requested Law 194/1978, is conducted with the woman seems important, particularly as regards the not strictly medical aspects. In particular, in the interview, it would be necessary to distinguish, a first phase that has the objective of providing social and psychological assistance, which should not coincide with the phase in which it is possible to issue the document as provided by art. 5, last paragraph, and it should involve more than health care expertise (the delivery of the aforementioned document not yet being involved, participation in this phase does not present problems related to conscientious objection). Assistance of a social nature should, among other things, make readily available to women all the contacts necessary to resolve material problems (of residence, employment, etc.).

Similar needs of assistance, support and reflection from the ethical point of view in the presence of the relevant factors pursuant to Art. 6 l. No 194/1978, in the ninetieth day of gestation and when there is a possibility of independent life of the fetus, although in this case the *interview* is not expressly required by law. Moreover, the need even in this context, for those requirements to be met through a phase, that although it is called an *interview*, seems to follow the general principle that any medical intervention must be conducted on the basis of adequate information relating to the concrete situation.

It would not be acceptable, both with respect to women's rights, and respect for the dignity of people with deformities or abnormalities, in the most frequent hypothesis as mentioned in art. 6 – when there is a serious danger to the mental health of the woman in the event of continuation of pregnancy with reference to "significant anomalies or malformations" of the fetus - consider the social reaction to recourse to interruption of pregnancy that is taken for granted.

The need for psychological assistance to the woman encompasses, of course, also the case in which termination of pregnancy has been carried out: if, in fact, it is true, that miscarriage requires elaboration of the mourning for the loss, it is all the more reason for necessary psychological support in the case of voluntary interruption of pregnancy.

6. The role of social policies – The bioethical importance of which must also be reiterated, for assistance to pregnant women, social policies in support of motherhood, especially with regard to the protection of families[3], single mothers, and lack of adequate financial resources as well as mothers of any job title, early

[2] It would not be constitutionally permissible for the problems concerning the termination of pregnancy that it could be dealt with under "a regime of total freedom on the part of the individual pregnant woman" (Constitutional Court. No 35/1997).

[3] Public investment for the family with respect to social spending in our country is much lower (4.2%) compared to that of other large European countries.

childhood services, to recognition of support from parents for the maintenance and education of children.

These factors are, in fact, fundamental preconditions for an effective recognition of the social value of motherhood and of parenting in general.

Particular attention must be paid to the protection of pregnant women immigrant who have immigrated illegally.

Assistance to pregnant women, therefore, requires different and complementary profiles of intervention, which encompass educational, psychological, health and social dimensions.

The confinement of a woman in solitude, whether material or moral, faced with the commitment of motherhood constitutes a radical breach of the same human dignity of that woman and her child, and at the same time represents the failure of the fundamental bonds of solidarity for civil life.

BIOETHICAL ASPECTS OF POST-PARTUM DEPRESSION

1. Childbirth and the puerperium – Before directly considering variations in mood that occur in the post-partum[4], but that may be present even in pregnancy and be prolonged to the postnatal period, it seems appropriate to mention the significance of the intercurrent stages between pregnancy, childbirth and the puerperium for a woman.

Childbirth is a caesura, a point of no return between a before and an after. Surpassing the biological separation of the boundary, though expected, imposes itself in all its concreteness and marks the transition, the end of pregnancy, and the new dimension of motherhood. The biological separation is a real critical point, which involves the breaking away from a previous state, and implies the formation of a new stance of the person in all its multiple aspects.

The path which leads from pregnancy to the new phase of the relationship between mother and child recognizes in accordance with the established psycho-analytical interpretation, some of the most significant points:

- the sensation of suffering, almost of shock at what is being lost, in other words, the loss of a part of oneself, one's own body, identified with her inner self on the part of women despite the awareness of the existence of the fetus;

[4] The term postpartum in this document is not intended in the strictly obstetrical sense as that period - according to the Italian regulatory classification – which includes 2 hours after expulsion or extraction of the placenta. It is understood in the broadest sense, as the period of existential experience succeeding childbith (meaning consistently endorsed by international literature), the duration of this period is difficult to define. The puerperium is classified, however, as a period of time beginning after the expulsion of the placenta (and thus also including the 2 hours of "postpartum" as by regulation) and ends with the resumption of cyclic ovarian activity. Conventionally, puerperium is assigned a period of 6-8 weeks because in that range there is usually a complete regression of the majority of the changes in pregnancy involving the various organs and systems. If the woman is breast feeding, during puerperium the activation of the breast function occurs (see Pescetto et al., Manual of Gynecology and Obstetrics, SEU, Rome 1989, p. 1063 ff.).

- the opening to the new that is acquired: the breaking away of the above-mentioned biological unit finds its match in psychological terms in the transition from the imagined child to the real child that can be touched and seen, with the possible disappointment in the perception of this divergence;

- The mother's need to manage the empty space that has been created and her attempts to fill it, with equal satisfaction.

All this is possible only thanks to a "regression" that is in some way driven by the baby, so the mother and the infant form a whole. Winnicott speaks of this particular state of fusion as a true *psychiatric state* very particular to the mother, a "normal illness", the so-called "*primary maternal preoccupation*", in which the mother can develop an instinctive understanding of the needs of the newborn, even without signals. This identification of the mother with the baby and the inherent regression permit the filling of the void created after delivery, fostering a sense of continuity with the intrauterine life. Gradually, the mother and the infant overcome the sense of separation caused by childbirth, and permit the baby itself to move from absolute dependence to relative dependence[5].

For its part the baby, that has not yet achieved a sense of integration, searches for a reality that includes it and that makes the baby feel more than just a voice or something that is perceived with the senses, and gives it a sense of continuity. The smell of the mother, the baby's pace, posture, way of moving and communicating only with the body, contribute in some way to restore it with a sense of continuity, that has been lost with the caesura of birth (Bion, 1979). What ordinarily permits the baby to re-establish the lost continuity with the resection of the umbilical cord is the mother's breast, and in particular the nipple that works almost like a second umbilical cord.

In the puerperium the mother often feels a sense of having "finally emptied" and at the same time, they have lost important parts of themselves. Only through a gradual process of developing these feelings, and not without alternation between moments of confidence and depression, does she usually put into action the natural transition to her new status as a mother. The completion of this psychological journey can be modulated, however, according to different paces, the characteristics of the woman, the couple, and the environmental context.

In light of these considerations, the best way to encourage the unfolding of the first rapport after birth between mother and child seems to be not to remove the infant from the mother except for a short time since, in so doing it allows both to be reassured, to adapt to one another and favours the eventual establishment of breastfeeding.

After delivery, through varying moods one moment confident and promising, and the next negative, the woman encounters the new condition of the child and the recognition of it in this new condition takes place by degrees, after months of the most varied fantasies.

2. Post-partum pathologies – The transition from childbirth to puerperium can occur normally, but there are also situations where adaptation to the new condition

[5] The transition from absolute dependence to a real interdependence, able to ensure to both "active adaptation to needs" is however a long and tortuous transition, and includes the puerperium.

of the mother proves difficult, so as to determine states of suffering and even anxiety, as far as decidedly pathological conditions.

The relevance of the situations founded in the *post-partum* is not limited to the distress and suffering of the mother but has a direct effect on the newborn child and the family. There are numerous studies showing that the infant at birth reflects, almost as in a mirror ("mirror neurons"), the mood of the mother, creating a short circuit with it that determines not only their mutual relationship, but that will also have an impact on the future relationship with the outside world.

The variations that may occur in the ways of adaptation to the new condition as a mother have provided a wide range of situations that differ in intensity and severity of mood disorders. It is difficult to give a specific order to clinical material that appears by its very nature extremely confusing due to the infinite and much discussed limits that the "organic" disease has both on the extreme polymorphism and variability of the psychiatric framework.

It seems appropriate at this point, to define the boundaries in which such complex psychological and existential situations must be considered.

These are situations that can blend into one another as in a *continuum*, but for nosographic simplification are shown in growing as "*maternal blues*", *post-partum* depression, puerperal psychosis.

"*Maternal blues*" (a term used internationally to indicate a mild postnatal depression in puerperium) is a transient mood disturbance that occurs in the early days of *post-partum* with a peak between the third and fifth day, with remission generally, around the tenth day, or more rarely a few weeks. It affects 50% of women (40-80%). Its persistence for longer, which occurs in a small percentage of cases, and the intensity of mood alteration suggest reconsideration of the diagnosis as it may be an indication of the evolution towards a form of depression. The apparent banality of the disease should not lead us to overlook this discomfort that is of a limited extent, also for the possible repercussions on the newborn child which have been mentioned.

The post-partum depression (PPD) which is part of a clinical picture of medium severity is considered the most common post-partum pathology. It occurs in approximately 10% of births, and is more common in adolescent mothers, but it can last from a few weeks to a few months, since one of its features is an evolution that tends to chronicity. If unrecognized and untreated it can continue even after a year of onset and extend indefinitely in terms of the negative impact on the child. Recurrence it is very frequent (1:3) in a subsequent pregnancy. Clinically the depressive symptoms are evident: loss of interest in normally pleasurable activities, psychomotor agitation, difficulty in addressing the more mundane events, uneasiness in dealing with interpersonal relationships, distress associated with fatigue, anorexia, weight loss, insomnia, feelings of guilt and above all inadequacy in the maternal role, with an excessive anxiety regarding the baby's health. In addition to melancholic depression, there are also those that are not mental that barricade themselves behind a "pragmatic system" by which the interaction with the child may also be excessive but it is devitalized and lifeless.

The most worrying situation is represented by the *post-partum psychosis*, which, however, occurs in a much more limited number of cases: 2-3 cases per thousand births. It can develop in the early days of the puerperium, usually in the

first weeks after birth but even after a few months. A woman in the first month after birth runs the highest risk of her entire life to be admitted to a psychiatric facility (Asch, 1992).

Approximately 70-80% of *post-partum* psychosis occurs in women who are prone to bi-polar illness (manic-depressive illness). The remaining 20-30% of the psychosis is manifest in women who are already ill before the birth, and they become unbalanced with the birth of the child.

Post-partum psychosis is often the first manifestation of a bipolar episode of the young woman and like all bipolar disease can last months and even years, unless appropriate assistance is obtained.

Peculiar clinical features are the surprising suddenness with which delirium occurs, the extreme polymorphism of delusional themes, the intensity of affective reactions and the inevitable confusion that reveals an acute process of deconstruction, of various degrees. The delirious productions generally develop on particular and recurring topics, such as the denial of marriage, childbirth, motherhood, the very existence of the child. It is often only during hospitalization that knowledge of the previous organization of personality is gained, through the accurate medical history (not only of the patient but also family members), which takes into account the prior history, both with regard to external events, both also to those of the inner world.

If the psychosis begins quietly, and is pertains significantly to depression, the mother may complain of insomnia and anxiety increased as a preliminary signs, but what inexorably increases is her anxiety concerning her *inability to care for the child*, especially as concerns breastfeeding. She fears that the child may die; she may drop it, or not know how to feed it, etc. A specific phenomenon is the transferral to the newborn child by the mother of her own depressive characteristics and her suicidal impulses. Feelings and thoughts like: "I'm useless, I’m evil" are transferred to the newborn baby. Instead of believing she herself is bad, or even the incarnation of evil, the maniacal fantasy can be projected onto the child, who becomes the object of disillusionment. When the new mother perceives the child as the quintessential "evil" like a serpent or the devil (see the movie and book, *Rosemary's Baby*), this is a moment of extreme danger. Suicidal impulses and / or infanticide often occur at this point: the mother can kill herself; sometimes she kills the child, and sometimes both herself and the child, jumping out of a window with the baby in her arms.

When the post-partum psychosis has maniac characteristics as opposed to those of depression, the woman usually manifests the typical signs of mania: euphoric excitement, excitation, grandiosity, hyperactivity, etc.

In extreme cases, infanticide occurs. The horrifying events of infanticide, often accompanied by the mother's suicide, are not always examined in depth or understood in regards to their tragic dynamics. Public opinion has largely polarized on the rise, touted by the media, of the number of trials for infanticide.

The issue has become a subject of study especially since the problem of abuse against children is seen as a social problem of the highest order. It is amazing how little information there is on the morbid condition of infanticide, despite its being known for some time along with its extreme gravity. This lack of information is probably due to the social unacceptability of such a crime and the

complex interweaving that for sentimental reasons are often employed as a cover up of the protagonist. It is therefore very difficult to have reliable facts, since, in all probability, some cases remain unknown.

According to different legislations there are various definitions of infanticide and neonaticide. According to Italian law infanticide is recognized as a particular situation, the same way as happens in almost every country in the world. Infanticide is considered the situation in which "the mother causes the death of his newborn immediately after birth, or the fetus during labor, when the fact is determined by material and moral conditions of neglect related to childbirth..." (CP Art. 578) whereas it is considered "murder" when the child is suppressed at any age, the same way as other homicides. Other laws provide instead a distinction between "neonaticide" (within the first 24 hours) and "infanticide" (within the first year of life).

The Italian data on infanticide denounce a progression over time (from 12 cases in 1998 to 63 in 2001: C. Petrignani, 2002). According to data from the United Kingdom the cases of suppression within the first year of life are between30-40 per year, of which one quarter are neonaticides.

A comprehensive and reliable overview on infanticide carried out by Resnick (1970) although dated, suggests that in England, each year, these are much more numerous. An estimate of the frequency of infanticide caused by *post-partum* psychosis in the United States suggests an annual rate of 400-500 cases.

Literature demonstrates that neonaticide is more related to contingent factors (first child, socio-economic difficulties, the woman being a single parent or immigrant), and infanticide (in the Anglo-Saxon sense) would refer mainly to a psychiatric disorder.

Among the alarming manifestations of *post-partum* depression the suicide attempts of the mother (in the psychological profile), in which, however, the child is made the object should be considered. The genesis of all this is a fantasy (conscious or unconscious) that the child is suffering and will suffer all kinds of evil, from which only death can save him. The unconscious dynamics of filicide, in this case, involves the projection of the self or at least a part of the self on the child. The death of the child implicates, in the light of this unconscious fantasy, the only way to eliminate terror and at the same time to get rid of what generates it.

3. Legal consequences with regard to imputability – On the basis of the considerations above it should be highlighted that the legal significance of the psychotic and psychopathological factors considered here must be recognized, especially with regard to criminal profile. These factors are in fact more readily classifiable among those that surely implicate the exclusion of imputability, granted that the women we are discussing undoubtedly have a radical anomaly regarding the representation of reality and the formation of will, together with the lack of motivation for the latter through regulation.

It should be stressed that the seriousness of the damaging event that is possibly committed (consummated or attempted neonaticide or infanticide) can not affect in any way, the legal recognition of state of non-accountability, when these factors subsist.

This recognition allows the woman concerned to express her problems frankly, inter alia, both before and after the possible committal of any criminal acts: which is to the benefit of effective prevention.

4. Etiopathogenetic factors of depression and postpartum psychosis – The pathogenetic interpretation of the scenarios that we have described is still not clearly defined. There are, in this regard, "psychogenic" hypothesis alongside others that are "neurogenic": the first rather inclined to exploit the related deep psychodynamic messages even as concerns the "lived" experiential factor, while the second is focused on the influence of genetic-constitutional factors, and however of an organic "predisposition" in a broad sense.

First of all, we need to recall the importance of the role they had in the description of the symptoms, and of the results of passed Schools directly or more broadly related to psychoanalysis (in the appendix to this document the pathogenetic interpretations provided by some of these Schools on the subject in question will be presented - albeit briefly).

One wonders, however, if it still makes sense to propose similar dichotomies faced with the close relationship between *psyche soma* and that are increasingly being documented by the neurosciences.

The uncertainties in the cataloging of nosographic *post-partum* mental health problems testify the complexity of interpretation of this subject. It is debated whether *post-partum* depression and psychosis (which according to the authors of Anglo-Saxon Minor and Major Depression correspond to the DSM IV - *Diagnostic and Statistical Manual of Mental Disorders*) should be considered specific pathologies to the period after childbirth or even during pregnancy: in other words, whether they should be seen as significantly associated with the event of childbirth or with the general chapter of mental illness. According to the DSM IV, the condition under examination comes under the chapter on psychosis (with the specification of "onset of psychosis in the *post-partum*"), since the general risk factors are considered prevalent to the specific incidence of childbirth.

The French school tends instead to give independent nosographic dignity to the psychosis of pregnancy and puerperium, meaning inclusively in the title "all the psychiatric accidents that are related with pregnancy, puerperium, and lactation": therefore, it becomes possible to give unity to material that would be confused in the maze of the various nosographic categories and emphasize a more precise causal connection between events.

The various attempts to highlight specific etiological factors of depression and *post-partum* psychosis have not obtained general consensus. The multifactorial genesis behind similar changes in mood, because of the intricacy of biological, psychological and socio-cultural factors, allows, therefore, only interpretive hypotheses that favor one model rather than another.

The endocrine component has variously been called into question, for the spectacle of the hormonal change that occurs after childbirth (in all women there is a sharp fall of hormones at the end of the gravidic process - estrogen and progesterone in particular - or related to it, such as cortisol) and analogously with other situations of a woman's life (menopause, premenstrual syndrome) that are associated with abrupt hormonal changes and mood changes that are connected

at least chronologically. However, in the face of such an endocrine situation, common to all pregnancies, there is in the puerperium a statistically modest mood changes.

In recent years, the data in literature has emphasized the effects of estrogen on brain structures and functions such as, among others, cognitive capacity, memory and mood. Such effects involve both the nerve cells, and the various neurotransmitter systems and their receptors. Estrogen, in particular, increases the *turn-over* of dopamine and dopaminergic receptors, as well as carrying on an active reductive effect on serotonergic and beta adrenergic receptors. Despite the existence of this evidence, there has not, however, been any experimental link found between estrogen and *post-partum* depression or psychosis. In addition, in this way, there is no explanation of late-onset cases, when the hormonal situation is being restored or has been normalized. Similar considerations can be made regarding progesterone, prolactin and cortisol, since in cases of depression and *post-partum* psychosis conflicting values of these have been found.

Among the potentially relevant biological factors the genetic ones should be considered, in terms of a predisposition to depression or more serious psychiatric conditions: in this regard valuable indicators can be found in personal and family history. It is known that the genome expresses the genetic potential, which, however, soon becomes, in relation to the environment, epigenetic individuality, that is, an organization of innate and acquired elements so that the same predisposition, which still remains however a certain risk factor, may be followed by different outcomes.

The etiopathogenesis diathesis-stress model involves interaction and the causal and systemic circularity between predisposition and stressful events, including environmental and behavioral ones.

Also with regard to biological factors, literature has found a place for the interpretation of depression in general as a "dysregulation" of serotonin neurotransmitters and other pyogenes amines such as nor-epinephrine, epinephrine, and dopamine. The role of these factors has in fact been studied also in relation to depression and post-partum psychosis, with however not consonant results.

The importance of psychogenic factors in the DPP finds broad consensus in the literature and the premises previously set out on the psychodynamic commitment that the phenomenon of pregnancy can involve and the doctor’s experience.

In this still uncertain framework of interpretation, research, that in many cases demonstrate a correlation between pre-and post-natal depression, should however be highlighted.

A similar correlation is found between *pre*-and *post-partum* states of anxiety. This confirms the "stability" of individual psychological behavior, despite the large mood, emotional and social variations experienced during pregnancy and *post-partum* (Llewellyn et al., 1997, O'Hara and Swain, 1996; HERON et al., 2004). There are, however, only reports of onset of depression in the *post-partum*, that is, not preceded by symptoms of depression during pregnancy (Da Costa et al. 2000; Josefsoon et al., 2001, etc.).

Taking into account these assumptions, the complex process that leads to the birth of a child must deal with multiple factors: genetic and epigenetic heritage acquired through destiny, the relationship with the family of origin, the events of life and the way in which they are experienced by individuals, the structure of formed personality, the atmosphere of the couple, the attitude to becoming a mother, the very experience of childbirth and, last but not least, socio-economic conditions.

5. Identification of risk factors and prevention of the mental pathologies of post-partum – The goal of prevention, associated to the early identification of risk factors, constitutes, with regard to the subject in question, the topic of most interest bioethically and the primary goal to be pursued, both in the very course of pregnancy and, in any case through the timely diagnosis of the first suspicious events of discomfort in puerperium.

The problem is being addressed clinically through the usual classical clinical order paths, for which the collection of anamnesis, the use of guidelines, and the experience of the physician take on fundamental importance.

Much space has been recently attributed to the search for predictive factors, to an approach that is generally based on semi-structured clinical interviews, the use of different tests on self-assessment questionnaires, all administered during pregnancy and after childbirth, in some cases up to one year after childbirth itself[6]. One of the aims would be to establish a reference platform to evaluate apart from the risk even the effectiveness of various therapies.

Even in Italy there are under study projects on depression and *post-partum* psychosis at universities (Pisa and Naples) and in Emilia Romagna. Abroad, we can cite, among others, research centers active in Geneva, Heidelberg and Cambridge.

A study by the *Canadian Task Force on Preventive Health Care* in 2003, faced with the wide range of tests available and the lack of reliability that they offer, especially in cases of medium severity, advises the doctor concerned to choose the method that best suits his personal preferences, the type of the population investigated and the practicality of the *setting*. These types of screening, therefore, are still considered as a working hypothesis.

The *American College of Obstetricians and Gynecologists* recommends that doctors are always alert to symptoms of depression and during case history to gather information about possible psychosocial stress, as well as a possible family history of depression.

[6] Diagnostic interviews generally follow the standard criteria of the DSM IV, which is a very useful tool to communicate unequivocally within the scientific community. The distinction between Major and Minor Depression is based on the DSM IV results, and corresponds, as noted, to the distinction between *'psychosis'* and *post-partum 'depression'* (it is the major depression easiest to identify through the various screening tools). Most widely used among the tests is the *Edinburgh Postnatal Depression Scale* (EPDS), especially to follow the results of treatment over a period of time; there are also proposed several types of tests and self-assessment questionnaires, which take into consideration various aspects including the spectrum of mood, obsessive-compulsive spectrum, the so-called *"Work and Social Adjustment Scale"*, the STAI (*State-Trait Anxiety Inventory*). There have also been attempts to assess the predictive accuracy of the different types of screening.

6. Therapeutic profiles of post-partum pathologies –The difficulties in formulating a diagnosis of DPP automatically fall on the choice of treatment to be implemented.

In a recent review of the literature in English from 1990 to 2003 (E. Cindy-Lee And Dennis D. Stewart 2004) therapy on the outcome of depression and *post-partum* psychosis, these are related to 'organic' and 'non- organic ' interventions, which indicates once again the basic dichotomy that exists in the interpretation of the issue in question.

The disease is considered with respect to the minor disorder (depression) and major disorder (psychosis), as the "maternal blues" effectively making use of care by the father of the unborn child and / or a "good mother figure" that looks after the mother.

The available studies, given their methodological characteristics and number are not however able to provide reliable and unique therapeutic indications: a brief account is therefore provided only for the sake of completeness.

a) Pharmacological treatments

As regards pharmacological treatment with antidepressants, literature is full of controlled *trials* on the effectiveness of this on depression in general, however, specific studies related to the DPP are noticeably lacking.

In the last decade selective serotonin *reuptake* inhibitors have been used as initial attack (SSRIs fluoxitina type, instead of tricyclic antidepressants) because they are freer from side effects and have a wide margin of safety for nursing mothers.

Apart from the fact that some of the studies considered as valid according to the selection criteria adopted in the meta-analysis combine at the same time from one to six *counselling* sessions with good results, the same overall conclusions drawn in the literature on the quality of acquired data and on deducible practical recommendations state that there is insufficient evidence to infer reliable therapeutic indications.

.There is also work on two hormonal treatments related to the administration of estrogen. In the first, however, the evaluated patients are very depressed, 47% of which were taking antidepressants. The results indicate an improvement in the early stages of treatment, but the findings suggest to expand the research to less depressed patients without other pharmacological interference and to seek to establish, through basic research, the role played by estrogen in the DPP.

b) Psycho-therapeutic treatment

21 studies were examined, including interpersonal psychotherapy, cognitive behavioral therapy, psycho-social interventions (support therapy, non-directive *counselling* also defined as a "listening examination"), and "mother-child" therapy.

Interpersonal therapy has achieved significant results in treated patients compared with controls. It is recommended, however, to wait long *follow-up* periods to compare the efficacy in relation to pharmacologist and psycho-social

treatments and to make use of personnel with a good level of training on the subject.

The cognitive-behavioral therapy, very widespread in English-speaking countries, is documented in six studies, but all have methodological limitations, represented, for example, by the low numbers, or lack of control group. The lack of inclusion of such therapy in the treatment programs of the DPP must also be considered in the conclusions regarding evidence. Its potential role is supported by reference to the effectiveness of the cognitive-behavioral approach to depression in general. Also raised are the problems of the considerable time required for implementation and the related cost elements conditioning *compliance.*

.Among the psycho-social interventions there has been attributed to "supportive therapy" a potential beneficial effect under certain conditions, especially in cases of moderate severity, however, the methodological weaknesses of the research makes the results ambiguous.

Also being tested is also a supportive therapy via telephone, through a large randomized trial.

Other approaches, as reported by some *trials*, include non-directive *counselling* and "Mother-child" therapy. These are interventions that may be a secondary option in the treatment of DPP in situations of medium or moderate depression. Once again, however, the methodological weaknesses of the *trials* make the results non-unique.

c) Other approaches

One work describes intervention involving sleep deprivation according to certain chronological criteria: the mechanism could restore good quality to sleep and re-establish the circadian rhythms which underlie this. The same *trial* calls, however, to further develop the research.

Electroconvulsive therapy also appears to have been taken into consideration, compared to cases with acute risk of suicide or psychosis resistant to the common therapeutic approach. The information is limited only to the cases examined, which are few.

A profile, which however, has received too little attention is the one concerning the role of the father of the unborn child, he can undoubtedly be a good source of emotional and practical support, as well as a valuable *trait d'union* between the woman and the other members of the family.

The need for support in the puerperium is now so great as to see activated various means of assistance, by setting up centers at the Departments of mother and child, at family planning clinics or by free associations such as the Italian Parents Movement, as well as research aimed at the various university centers aimed at the care of women with depressive disorders in the puerperium and the parallel observation of the child, given the impact that these disorders can cause. Details of these are readily available online.

In England prevention has become systematic and has become part of the measures required in all hospitals that are part of the National Health Service, with the establishment of the *"Perinatal Mental Health Team*".

The availability of social support should be part of the institutional tasks, possibly with an external support at home for the care of the child.

In conclusion: the difficulties encountered in establishing the correct diagnosis - much less concrete than in other areas, especially in cases of medium severity - give an account of the uncertainties that arise in dealing with the question of therapeutic conduct. The constant reminder of the need to set up new studies that might lead to comparable data is testimony of the current state of provisional of each behavioral pattern.

The multiplicity of etiologic factors makes the event of unambiguous action unlikely: it must be noted that, as the causes are multifactorial, so are the treatment needs, only an approach which takes account of biological, psychological, and social factors and knows how to use one therapy or the other, alone or in combined treatments, can give successful outcomes, that should be considered, even if temporarily indecisive in terms of evidence.

7. Summary and Conclusions from the bioethical standpoint – The potential and real gravity of the syndrome of depression during pregnancy and especially *post-partum* calls into question the responsibility of care, in the broadest sense of the expression, which has already directed to every woman during the course of a normal pregnancy.

According to the majority of authors (see, for example, Kumar and Robson, 1984; O'Hara et al., 1984, Watson et al., 1984, Campbell et al., 1992, O'Hara and Swain, 1996; Bernazzani et al. 1997; Discard-Veltem et al. 1998; Da Costa et al., 2000; Beck, 2001; Logson and Usui 2001; Verkerk et al. 2004; Mac Mahon et al., 2005), the search for " risk factors " at the onset of *post-partum* depression is necessary in the course of prenatal care, on the basis of the following factors: family history of *post-partum* depression, a history of psychopathology, conflictual relationships with parents during childhood, bad marital relationships, low self-esteem, a low socio-economic level, absent or inadequate social support, stressful life events, and unplanned pregnancy.

However, an evaluation, during pregnancy, of the specific importance of the individual case of each of the factors mentioned, and of the "intensity" of risk is currently problematic: while some authors (e.g. Cooper et al. 1996; Nielsen Forman et al. 2000; Verkerk et al., 2003) believe possible the identification of individuals who will present a higher probability of depressive episodes in the first three months of the puerperium, other authors do not consider the utilized tests appropriate for the required purpose, or consider the observations made still insufficient.

In any case, the detected presence of 'risk factors' directs to closer monitoring and possibly towards adoption of appropriate pharmacological and psychological therapy.

Assistance to women during pregnancy, childbirth and puerperium, is a priority for the value of what is at stake. The interplay between the biological and psychological dimension which involves the mother, child and their mutual relations is so close and full of immediate and future consequences, especially for the newborn child, that it deserves special attention both in terms of research on an operational level, in order to effectively have an impact on this fundamental life

process. If this assumption has a general value for apparently normal situations, it is even more important in cases where there is a particular weakness, which exposes to the risk of psychiatric disorders.

The extensive literature based on the mother-child observation with the various methods available today clearly points out the possibility that the mental suffering of the mother has an impact on newborn child, whether overt or implicit. It is not necessary to recall the most challenging cases of the *post-partum* pathology: the anguish of the mother**,** both psychological and physical, the sense of loneliness when many mothers feel submersed, often connected to really being left alone, which can alter the flow of communication between mother and child by depriving the baby of the affectionate atmosphere favourable to its harmonious development.

The characteristics of "good care" conditions effective at least to reduce risk conditions or immediately prevent the worsening of them can be specified as follows:

- Assistance to women who are experiencing such fundamental situations requires the specific training of those who, having various skills, are involved in the health care itself, Frequent comparison among the figures involved in this sector that have a common basic formation and who are attentive to everything that is newly added to their discipline and is validly attached to health policy.

- It is necessary to create the conditions for a good relationship between those treating the woman, the woman herself and the father of the unborn child: the relationship should go beyond "good clinical practice" and provide the ability to listen and a refined sensibility to discern the states of 'mind and perceive risk situations. In addition to the theoretical training that should be provided to this effect in the schools of specialization for Obstetrics, there should also be 'training' in real clinics in interdisciplinary working groups (such as Balint, for example) that are open even to non-medical health personnel, in order to compare and discuss the methods of approach that are most useful and effective in prevention, "cure" and "care".

- It would be desirable to have continuous and proper prenatal care, preferably with the same *equipe* or with a homogeneous *equipe*, based on trust, in a sort of "therapeutic alliance" not only to evaluate the organic parameters but also to understand, give answers to many questions, and offer advice.

- There should also be a good preparation for childbirth and the woman's introduction to the environment where she will give birth (an issue already addressed in the NBC document *Pregnancy and childbirth from the bioethical standpoint* April 17th 1998).

- The request for a psychiatric consultation should take place when there is the need for wider experience to understand the clinical case. There could also be provided alternatively, especially in public health care, a "routine" consultation with a psychiatrist towards the end of the pregnancy, thereby mitigating the possible negative connotations that this proposal may have for some.

The current reality of hospital discharge quickly after childbirth reduces significantly the time of contact between the mother and the nursing staff, who are the most suitable for their physical proximity to perceive "something wrong" and to allow the mother in a confidential environment to give voice to her state of mind:

boredom, bad mood, lack of pleasure interacting with the baby and so on. The woman giving birth often finds herself so quickly alone at home with the father of the newborn child, or even without him, having to manage the care of the child with a thousand doubts and uncertainties, and without a moment to rest to calmly live this new experience. The awareness of the father of the unborn child and the family as a natural support, at least in the first phase, is to be saught and in special cases, external home support through the social care services should be provided.

In this regard the family should be made aware of the situation and, especially, the father, calling him to his responsibilities and moral and legal obligations as well as to the importance of his involvement in both the period of gestation and *post-partum*. Great help can be provided by the Centers which have previously been referred to.

The culture of childbirth, given its profound bioethical and social value, should pervade the whole of society and consequently the public health service. DPP represents an important aspect of the many difficulties which "coming into the world" puts forward and it underlines how the only way to deal with them is collectively, that is to say by focusing on the value of the human being, related to each component of the family[7].

[7] As part of investigations for the preparation of this text on *post-partum* pathologies, the *National Institute of Mental Health* (Washington DC) has been consulted, among others, and specifically Karen S. Babich, *Director, Office of Global Mental Health*, with a request to transfer the contents of the latest research on the subject of DPP. The reply expressed regret at the scarcity of available research.

APPENDIX - *Some notes of psychological and psychoanalytic literature.*

There is a vast amount of literature on the subject of pregnancy and childbirth from a variety of different points of view (psychological, psychiatric, and psychoanalytic), as to this a little bibliographic clarification, useful to anyone wishing to learn more, is here proposed.

In relation to the evolution of thought towards the subject of pregnancy three major strands can be highlighted.

A first group of studies, the most ancient, primarily interested in the meaning that the desire for children has for the woman, was developed by S. Freud, H. Deutsch, and M. Klein.

. A second line of research aims to identify, in the course of pregnancy, the different psychological phases of the woman with specific anxieties and conflicts. G. Bibring, and with her many others AA., distinguish at least two basic stages: the first, goes from conception to perception of the first fetal movements, characterized by an adaptation to perceiving the fetus as part of herself and therefore to live out this fusion, and a second stage, which extends up to the birth, whose job it is to prepare for the separation that will ensue.

A third, more recent point of view, studies in a longitudinal manner the changes that occur in women regarding self-representation, the child, her parents and the father of the unborn child at various stages of pregnancy and for a few months after birth; it is in this context that ideas are also considered on maternity and child care developed by the woman during pregnancy and on the *maternage* that will actually be provided to the baby after birth (Raphael-Left 1983).

By correlating the analytical observations with hormonal investigations, Benedek (1956) believes that the increased hormone production is interdependent with the specific receptive tendency of the woman, identifying the correspondences between physiological changes and psychological tendencies during pregnancy. Motherhood is not a secondary event, but the expression of the pervasive instinct to survive through the child: and is the organization of the sexual instinct of the woman, and also of her whole personality.

Looking more generally the most significant contributions that have occurred over the last fifty years, special recognition goes to G. Bibring. For this author (1959-1961) pregnancy is a maturational crisis leading to a new position, not identical to that experienced previously. As a maturation crisis (similar to the crisis of adolescence and the menopause) pregnancy implicates regression, relaxation of defenses, changes in the organization of the sense of self, new identifications, preparing the woman to live "in the child", seen as subject / self then as an object separate from her. G. Bibring has also proposed to identify the most important moments of pregnancy and the *post-partum*, but the identification of these stages has remained rather vague. The crucial moment for Bibring comes when the woman begins to feel fetal movements, which coincides with what Winnicott referred to as the phase of "primary maternal preoccupation," and which he saw extended also to the first months of life of the child.

D. Pines (1972-1982), accepting the theory of Bibring that sees pregnancy as a maturational crisis of the woman, emphasizes that, especially in the first

pregnancy, there is the reliving and completion of the process of separation-individuation from her own mother. Pines also believed to be able to discern a significant difference between the psychological "desire for pregnancy" and the "desire for children", the first constitutes the demonstration that her body functions like her mother's body and the second is an expression of a real desire to have a child.

In the wake of Bibring, but with a completely original work of research, F. Ferraro and A. Nunziante Cesaro (1985) interpret pregnancy as a kind of "act" between conception, pregnancy and birth: a psychological elaboration that brings about a new equilibrium of maturity as a specific construction of female identity, but which can also entrench regressive forms of defense. A.A. have questioned the concept of maternal instinct, as well as the that of motherhood, as a last and unavoidable step in the acquisition of true adult female identity. No doubt there is a biological drive to procreate, as in all other animals, but in humans things are much more complex and that is why to the word "maternal instinct", the term "maternal feeling" is preferred, a word that evokes a greater complexity, ambivalence included.

In this regard, the notion of primitive rivalry is cited, that E. Gaddini (1982) describes as a love modeled on imitation: "the magical identity with the mother, consented and nurtured by sufficiently good maternal care, through gradual experiences of frustration and separation, the girl child (and the boy, of course) begins to perceive herself as separate, and from this time fantasies of fusion with the object of love are triggered which express the desire to restore the lost unity".

According to Bollas (1990) already in the womb there is the notion, not thought - Bollas speaks of "known", not "thought" - of being part of a human process (a process that Winnicott had indicated as a *holding environment*) and to live in a constantly changing environment. As soon as the individual is born, the transformative role played by the mother will join the transformative presence of the father, so the child will "understand" even better than it is in a very particular family, with its own way of being and communicating.

Indeed, it is quite some time that we have been wondering whether the capacity for maternal care begins with fertilization, or if it belongs instead to the personal history of the mother as a person, or the mother and father as a couple, with regard to their ability to feel (and express) concern and their ability to share states of mind and feelings with another person, whether it be the fetus or newborn child. It can be assumed that primary maternal preoccupation exists at least from the first fetal movements (today, indeed, it is increasingly linked to the very awareness of the woman to being pregnant, which can now be acquired very easily), and that is entirely conditioned by the personal history of the mother, as mentioned above.

The mother's empathy, or *reverie*, or projective identification, so important to give the child, from the beginning, the sense of being wanted and respected as an individual, borders on the bonds of reciprocity, identified by Bowlby (1962) as "attachment "and Winnicott as" reciprocity "that will herald the sense of *playful exchange* right from the very first shared human rapport.

In recent decades great changes have taken place in t social and sexual behaviour of women and their implications are being integrated in psycho-analytical theory.

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