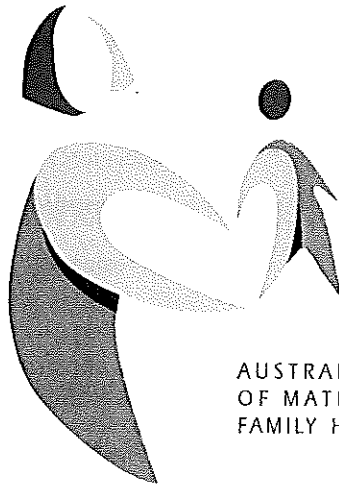


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ERRATUM

The Editorial Committee sincerely regrets that in the October 2008 edition of the Journal, the name of the author, Dr Sarah Landy, was inadvertently omitted from the article 'Preventing intergenerational trauma: intervening with parents with

unresolved loss and trauma'. The Committee apologises for this most unfortunate error, which occurred during the production process.

Dr Landy is a developmental-clinical psychologist with many years experience in child mental health who currently works at Family Pathways, Princess Margaret Hospital, Perth, WA.

She has published several books including 'Pathways to Competence: Enhancing the emotional and social development of young children'; 'Pathways to Competence: A parenting program'; and 'Early intervention with multi-risk families: An integrative approach.'

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A CRITIQUE OF SCREENING FOR POSTNATAL DEPRESSION USING THE EDINBURGH POSTNATAL DEPRESSION SCREENING TOOL IN WESTERN AUSTRALIA

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Introduction

Postnatal depression (PND) is a confronting health problem, affecting the woman, her partner (if present), her child(ren), her family and the wider community, which often attracts considerable media attention due to the seriousness of the issue. This paper identifies what PND is, as well as outlining its prevalence and the consequences for family relationships and child development. Next, the paper evaluates a protocol for screening for PND offered by the Western Australian Department of Health and then assesses the appropriateness of using the Edinburgh Postnatal Depression Scale (EPDS) as a screening tool. The review includes assessment of the protocol in terms of its suitability for the target group of mothers attending the child health clinic at the routine six to eight week appointment. Finally, suggestions to improve the protocol, which has implications for clinical practice, are offered.

Postnatal Depression

There is a difference between PND and the baby blues. The literature describes the baby blues as a time of extra sensitivity, when postpartum women feel tearful, irritable or low (Pope & Watts, 1997; WA Department of Health, 2008). Typically, 80 per cent of women experience this in the first week after the birth. With support, empathy and patience these symptoms usually disappear within the first two weeks. A study by Fishbein and Burggraf (1997), which included a convenience sample of one hundred healthy women, identified that more than one quarter of the women experienced further depression after the first two weeks postpartum. However, there is inconsistency in the literature with regard to rates of PND in Western countries, such as Australia. Pillitteri (2003) states the figure is higher, whereas Armstrong and Small (2007) and Coyle and Adams (2007) suggest that PND affects between one in seven or one in ten. Alarming, Armstrong and Small (2007) suggest that 50 per cent of PND cases are not detected.

Postnatal Depression is clinical depression occurring at any time during the first postnatal year (Pope & Watts, 1997). PND is an illness that may last for just a few weeks or if untreated, may persist for a long time and become debilitating

(Reagan, 2005, p.392). PND may include symptoms in the areas of emotions, behaviours and thoughts. Emotions may be experienced as any of the following: low moods, tearfulness, guilt, shame, confusion, anxiety, panic, fear of the baby, fear of being alone, and fear of going out. Behaviours may manifest as: a lack of interest in usual activities, insomnia or excessive sleep, eating disturbances, decreased energy, social withdrawal, poor self care and the inability to cope with routine tasks. Thoughts that may occur include: the inability to think clearly, lack of concentration, poor memory, wanting to run away, being rejected, causing harm or death to their partner or baby, and ideas of suicide (Department of Health, 2008).

The significance of Postnatal Depression for child development

Research consistently shows that maternal mental health is inextricably linked with the development of the baby (Armstrong & Small, 2007; Campbell, Hayes & Buckby, 2008). Coyle and Adams (2002) reiterate this point, stating that "numerous research studies over recent years have demonstrated the deleterious effects on the cognitive, social and behavioural development of children whose mothers have suffered from PND" (p.394). Kendall and Li (2005) suggest that psychological capital, encompassing the mental health of the parents, is a resource which is critical for parenting and early socialisation. They further explain that the process of neural sculpting occurs in the early years of life whereby the child's interaction with caregivers plays a significant role in determining how the child's brain is "wired-up". During the first three years, over one third of neurons in the cerebral cortex are eliminated and there is a major expansion of synaptic connections as well as a massive elimination of these synapses (Cynader & Frost, cited by Kendall & Li 2005, p.2274). It is clear that early childhood is the most critical period for neurological development (Kendall & Li, 2005, p.2274) and it is likely that for some children at least, PND impacts negatively on this process.

When a mother is not communicating effectively with her baby, because of PND, there is a greater chance the infant will not become securely attached. Securely attached infants are more likely to become secure toddlers, socially competent preschoolers and academically skilled and better parents (Berger, 2008 p.196). Stressors in the family have an impact on attachment. The mother's sensitivity is the best predictor of a child's social skills, but day care can have an effect too.



The literature suggests that if the child cared for at home is cared for by a depressed parent, then they fare worse than if they were in centre care (Loeb, 2004 cited by Berger, 2008, p.199). In other words, if the mother is not stressed for example about income or her marriage, and she is sensitive to her child's needs, then the chances of a securely attached child are higher (Berger, 2008). Research shows that quality of maternal care is more important than the specifics of care (Berger, 2008 p.198). It is therefore critical that PND is identified and treated, in order to foster healthy maternal-infant attachment. It is also important for the health and well-being of any other children in the family and overall family functioning (Pillitteri, 2003, p.714).

The Women and Newborn Health Service of Western Australia (2009) has identified that "maternal anxiety and or depression may be associated with later problems in the infant's temperament, behavioural reactivity to novel stimuli, delayed motor and cognitive development and childhood problems, such as anxiety and reduced attention span" (p. 5). A recent article (West Australian, 2009) quoted Dr Jonathan Rampono, Head of the King Edward Memorial Hospital Psychological Medicine Department, as saying "you can influence the foundations of the next 80 years of your baby's life in the first year" ... and ... "the risk to the parent-child relationship and to the child's social and psychological development are profound when PND goes untreated" (p. 6).

Protocol to address postnatal depression

The Women's and Children's Health Service of Western Australia states that a policy is "an operational statement of intent, a rule that has legal connotations [and] compliance is mandatory" (2003, p.1). The WA Department of Health states that "a policy is a brief statement of position indicating intention and direction and enabling decision making" (2007, p.1). A protocol is a precise and detailed statement, steps or sequential set of instructions which may be based on a policy, clinical guideline or corporate guideline to meet the Health Service's conditions and constraints, which has legal connotations (Women's and Children's Health Service, 2003, p. 1).

The WA Department of Health (2007) clearly states in the Community Health Policies, Procedures and Guidelines Manual for Community Health Nurses that "the Edinburgh Postnatal Depression Scale (EPDS) should be offered to all mothers on two occasions (preferably three) after the birth of the baby, at 6-8 weeks, 3-4 months and 8 months" (section 3). This statement is made within the context of a policy, procedure and guideline framework; it is not actually a protocol. However, for the purposes

of this paper, the above statement and subsequent suggestions offered in the WA Department of Health (2007) manual regarding postnatal depression and specifically the EPDS as a screening tool, will be reviewed as if it were a formal protocol.

The EPDS is a 10 item self-report questionnaire developed as a tool for the assessment of post natal depression, but it can also be used antenatally (WA Department of Health 2009). For each item, women are asked to select one of four responses that most closely describe how they have felt after the last 7 days. Each response has a value of between 0 and 3 and scores for the 10 items are added together to give a total score (Women and Newborn Health Services, 2009). Davidson (2009) identifies that the EPDS is available in 36 different languages with 18 being validated.

Referral point: variation in suggested "cut-off" scores

The WA Department of Health documents: Perinatal Depressive and Anxiety Disorders (2009) and Community Health Policies, Procedures and Guidelines (2007), both agree that a score of 12 or above in the postnatal period requires referral of the client for further assessment. This cut-off score is supported by other authors, who acknowledge that there is consistent agreement in the research literature that mothers who have a score of 12 or above have a 60-100 per cent chance of meeting diagnostic criteria for depression (Campbell, Hayes & Buckley, 2007, p.127). Matthey, Henshaw, Elliott and Barnett (2006) suggest that a cut-off score of 13 or more is recommended when reporting on probable major depression in postnatal English-speaking women.

Armstrong and Small (2007) cite research in which the suggested cut-off score for referral is 13. This is consistent with the current WA Department of Health Training Manual (n.d.) which states: "all women with scores over 13 and clinical indicators of depression should be referred for specialised clinical assessment" (p. 9). It is interesting to note the inconsistency between the Policy, Procedure and Guideline (WA Department of Health, 2007) and currently used EPDS Training Manual (WA Department of Health, n.d). They suggest different cut-off scores for referral. Davidson (2009) notes that there are different cut-off scores for women of different nationalities. Furthermore, Campbell, Hayes and Buckby (2007) note that some authors suggest that the scale might need to be used more cautiously than previously suggested.

Recommended or mandatory?

The Community Health Policy, Procedure and Guideline Manual (WA Department Of Health, 2007)

suggests that the EPDS is easy to administer and score since it was specifically developed to screen for PND, and that it sometimes encourages women to talk about their problems. This claim is supported by a large Victorian study involving 267 women, evaluating the effectiveness of the EPDS (Armstrong & Small, 2007). During this study the "nurses comments suggest that the completion of the EPDS may have acted to facilitate discussion between the mother and the nurse and as a gateway to services" (Armstrong & Small, 2007, p.60). A major finding of this study was that 50 per cent of cases of post natal depression are not being recognised (Armstrong & Small, 2007). This brings into question the wording of the WA Department of Health policy (2007) that women "should" be screened with the EPDS at three suggested time points. The issue is raised: Why is it not mandatory to screen women for PND at these time points? Armstrong and Small (2007) noted in their study that there were occasions when Victorian nurses used their clinical judgement and declined to use the EPDS to screen for PND. They report nurses' comments, such as: "with twin visits there was not enough time" (p.59) and "mother arrives late for appointments, it is hard to engage" (p.59). These subtle examples indicate that there may be opportunities missed when the EPDS screening is omitted. As Coyle and Adams (2002) state: for the screen to be valid the EPDS needs to be administered by a trained professional who has sufficient time and privacy.

Cultural safety

The EPDS has been identified as a reliable and valid tool to screen postnatal depression (Campbell, Hayes & Buckby, 2007; WA Department of Health, 2007) However, the application of the EPDS as a screening tool is not without its critics. The findings of several studies indicate caution when using the EPDS with non-English speaking mothers and mothers from non-Western cultures (Coyle & Adams, 2002; Campbell, Hayes & Buckby, 2007; Andajani-Sutjahjo, Manderson, Astbury, 2007). It has been suggested that the EPDS can pose cultural difficulties for interpretation (Coyle & Adams, 2007, p.394). Campbell, Hayes & Buckby (2007) reiterated this claim following a recent action research evaluation of the use of the EPDS with 181 Aboriginal and Torres Strait Islander women in Queensland. They found that although many of these women speak English perfectly well, it is often not their native language and that as a result, subtle misunderstandings can occur in the interpretation of terms. The women were offered a translated version and a standard version of the EPDS and while the research did not determine which version were more valid or accurate; the translated

version was found to be more culturally acceptable, and as a result yielded a higher rate of women with perinatal depression (Campbell, Hayes & Buckby, 2007, p.125). Similarly, Grusso and Quatraro (cited by Campbell, Hayes & Buckby, 2007) cautioned the use of the Italian language version of the EPDS for Italian women in its current form.

Another recent study, this time of urban Indonesian women with PND (Andajani-Sutjahjo, Manderson, & Astbury, 2007), has identified that depression may be spoken about differently by people from different cultures. The study highlighted that "how women experience, understand and speak of their emotional and mental status is clearly different" (Andajani-Sutjahjo, Manderson, & Astbury, 2007, p.114). The Community Health Policy, Procedure and Guidelines Manual (WA Department Of Health, 2007) suggests that the EPDS "is available in a number of different languages which will assist health professionals when working with [Culturally and Linguistically Diverse] clients". The policy fails to suggest how the nurse can take into account the cultural context in which it is used.

Fathers and perinatal depression

The Community Health Policy, Procedure and Guidelines Manual (WA Department Of Health, 2007) also mentions recent changes in the structure and function of families, noting that there has been an increase in the proportion of lone parent families, step parent families and blended families. There is also an acknowledgement of the challenges facing families, such as the changing nature of work, family stability, extended family support, and child care. While these family issues are identified, the Manual makes no suggestion that the EPDS be used to address the mental health of fathers. And yet, Campbell, Hayes and Buckby, (2007, p.124) suggest that the EPDS maintains its robust performance for screening fathers for depression perinatally. Batchelor (2009, p.6) identifies that "there has been an increase in the numbers of men coming forward for assessment and treatment themselves". According to the Head of the King Edward Memorial Hospital Psychological Medicine Department, Dr Rampono: "studies have reported the incidence of depressive symptoms in men whose partners had the condition could be as high as 40 per cent" (2009, p.6). The Statewide Obstetric Support Unit (WA Department Of Health, 2009) reiterates the father's vulnerability stating that: "fathers may become depressed or anxious, often in tandem with their spouses, but may be reluctant to admit problems because their perceived role is to support the new mother" (p.9).

Conclusion

It has been established that screening using the



EPDS is a key step in addressing maternal PND. The detection and treatment of PND is, in turn, critical for achieving healthy mother-infant attachment which then influences healthy child development. It has also been made clear that, while working for the Department of Health in Western Australia, Community Health Nurses are expected to work within the framework of the Community Health Policies, Procedures and Guidelines Manual (WA Department of Health, 2007).

In light of this, it is firstly suggested that the Policy, Procedure and Guideline Manual (Department Of Health, 2007) requires review regarding the appropriate EPDS cut-off score for PND referral. Secondly, it is suggested that the wording of the Manual is changed so that it states that the EPDS is to be used, rather than recommended as a matter of usual practice. Thirdly, it is suggested that the section on "cultural considerations" be rewritten so as to be more informed by recent research findings. With an increasingly diverse multicultural population this has great implications for nursing practice. Fourthly and finally, it is recommended that the WA Department of Health undertake a review of the identification and management of the father's potential state of depression, using the EPDS, and that new guidelines be included in the Manual.

Despite the limitations of the EPDS as a screening tool for PND and the deficiencies of the current Western Australian Community Health policy manual, this author is convinced that both the EPDS and the Manual will continue to play important roles in the detection and management of PND in Western Australia.

The author would like to thank Garth Kendall, Ailsa Munns and Lesley Kuliukas for their kind encouragement and assistance in undertaking this Paper.

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