



## Original Article

# Use of Edinburgh Postnatal Depression Scale (EPDS) in a private obstetrics setting

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### Abstract

**Objectives :** To document the feasibility of use of Edinburgh Postnatal Depression Scale (EPDS) in a private obstetric setting. **Methods :** Consecutive 55 antenatal and 30 postnatal women completed the EPDS self-administered questionnaire. **Results :** All the women readily consented and completed the questionnaire. None of them reported feeling uncomfortable doing the questionnaire. Questions related to laugh and see funny side of things, things getting on top of me, and look forward to enjoyment to things were found to be difficult for comprehension. Analysis of the responses revealed that 56% of the respondents (53% antenatal and 63% post natal women) scored  $\geq 9$  in the EPDS indicative of being at a greater risk for depressive episodes. **Conclusion :** The ready acceptance of the women to undertake the EPDS indicates that it could routinely be used for screening depression by a busy private obstetrician.

**Key words :** Edinburgh Postnatal Depression Scale (EPDS), mental health, missed opportunity

### Introduction

Depression in the postnatal period has a major influence on the health of both mother and child and has an impact on the growth and development of the child<sup>1</sup>. The World Health Report 2001<sup>2,3</sup> identified depressive disorders amongst the women in the 15 to 44 year age group as the second leading cause of disability adjusted life years (DALY)<sup>2</sup>. Studies from South Asia have confirmed the presence of a substantial burden of maternal depression in the region<sup>3</sup>. The prevalence of postnatal depression was

found to be 23% by Patel et al<sup>4</sup> while, the community based study from India by Chandram et al<sup>5</sup> reported an incidence of 11% (7.1% - 14.9%) and a prevalence of 16% before delivery to 20% in the postpartum period.

Altered or depressed mood especially during the third trimester and in the postnatal period is not an uncommon phenomenon and is prevalent across different cultures<sup>6</sup>. Several studies undertaken across the globe have indicated the benefits of early identification and prompt treatment of antepartum and postpartum depression<sup>7,8</sup>. However, it goes largely unrecognized and when managed, the treatment provided is inappropriate<sup>9</sup>. In countries like India, recognition and management of depressive conditions during ante-natal and post-natal period have received little importance from both patients and the provider. This is largely attributed to cultural issues. While efforts have been made in large or

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academic institutions to manage and treat common mental disorders in antenatal and post natal period, there have been no significant reports from the vast private sector facilities.

Recognising the missed opportunities different instruments have been used to detect antenatal and postnatal depression. These include the General Health Questionnaire, Revised Clinical Interview Scale, etc. The Edinburgh Postnatal Depression Scale (EPDS) <sup>10</sup> has been a notable effort in this respect. Being specifically developed on postnatal issues and concerns, the current study utilized this instrument. EPDS is a self-reporting 10 item questionnaire developed to assist primary care health professionals to assess postpartum depression and was developed in the health centres of Livingston and Edinburgh. Several studies have utilized EPDS as a screening tool to identify cases of postpartum depression <sup>11,12</sup>. Apart from being used to detect postnatal depression EPDS has also been used to predict postnatal depression <sup>13,14</sup>. Despite its wide use, its major limitation has been that it does not screen mothers with anxiety neuroses, phobias or personality disorder <sup>10,15</sup> (Sheelay S, 1987). Indian language versions of the instrument has also been developed and validated (Konkani – Patel et al, 1998, Kannada – Chandra P – Personal communication). The current effort was undertaken to explore the use of EPDS in private obstetric ISO 9002 certified hospital.

## Methods

Consecutive 55 antenatal and 30 postnatal women visiting the facility from 26<sup>th</sup> March to 25<sup>th</sup> April 2006 were studied. Each one of them was requested to complete the EPDS self administered questionnaire. For those who consented, they were requested to give a feedback particularly regarding reporting the self administered questionnaire, the difficulty they faced in answering the queries, etc. On a smaller subsample of women (n=5), a detailed word to word and phrase to phrase comprehension of each of the questions was also made by one of us (RP).

EPDS enquires into sadness, sleep disturbances, crying spells, suicidal ideation, hopelessness, and low self esteem and provides for a score ranging from 0 to 3 based on the dimension of the question (i.e. 0

to 3 or 3 to 0). The maximum score possible is 30. A score of 9 and above is accepted to be a cut off for identifying those at a greater risk. . A score of 12 and above is presumed to be indicating suffering from deression

## Results

The average age of the antenatal mother was  $28 \pm 3$  years while that of postnatal mother was  $29 \pm 3$  years. Majority of them were primigravidas (antenatal group 60%; postnatal group 70%).

All except three women readily consented and completed the questionnaire; three did not return the questionnaire (2 antenatal and 1 postnatal). On a general note, some of the women were apprehensive about how the information provided would be put to use. Secondly, though there was a specific instruction not to discuss the questionnaire with spouse or any other family members, about one fourth of the post natal women were observed to have discussed it with their husbands.

None of the women reported feeling uncomfortable doing the questionnaire. Despite the fact that all the women were educated in English, three questions were reported to be difficult to comprehend; The question “laugh and see the funny side of things” intended to explore the feeling of being able to lighten up a difficult situation(s), was perceived as mere laughter. Reflecting on the language usage in Indian context, things getting on top of me was not understood and needed frequent clarification. The question looked forward to enjoyment to things was perceived as the time spent with family rather than the intended insight of a positive outlook to the present situation. Further, most of them remarked that being anxious or worried, panicked or scared was a normal phenomenon happening most of the times, as also sleep disturbances.

Table 1 gives the EPDS scores of the study population. It is evident that 56% of the respondents 52.7%; antenatal women; 63%; postnatal women scored  $\geq 9$  and thus could be considered to be at risk for a depressive disorder. Of those at risk nearly every other women 45% of the antenatal cases and

53% of postnatal cases at risk have scored above 12 indicating the greater probability of them being actually depressed. However, no woman was documented to be having a psychological problem in the routine medical records.

**Table 1. EPDS scores of the study population**

Score					Total
	<9	9-10	11-12	>12	
Ante natal	269 47.3	7 16.4	13 12.7	55 23.6	100.0
Post natal	11 36.7	4 13.3	5 16.7	10 33.3	30 100.0
Both Ante- and Postnatal	37 43.5	13 15.3	12 14.1	23 27.1	85 100.0
% within Scores	100.0	100.0	100.0	100.0	100.0

## Discussion

The phenomenal burden and the significant impact of common mental disorders like depression and anxiety, has resulted in several efforts to link up service delivery at the primary care level. In India incorporating postpartum depression into the maternal child health (MCH) services has been a relatively new initiative. Hence, published literature on EPDS use in the Indian context is not much <sup>5</sup>. There is a specific need for introducing diagnosis and appropriate management of maternal mental health problems in different categories of health care settings as a specific service delivery component. There has been a recent attempt to develop guidelines for managing mental health during pregnancy <sup>12</sup>.

It is generally acknowledged that mental health problems, especially common mental disorders do not get the required attention in routine health care delivery. A key barrier is the recognition of the condition by the health care provider. Girish N et al <sup>17</sup>, in their case vignettes study regarding skills and practices of doctors in the maternity homes of Bangalore City Corporation found that though majority of the doctors were conversant with the diagnosis of anxiety and depression, their management skills for the specific conditions was quite lacking. In addition, several operational and

service delivery issues need to be addressed, chief among them being lack of appropriately trained human resources and absence of a functional referral and follow-up services. It is in this context that the current study attempted to use EPDS as a self administered questionnaire to explore the possibility of using it as a screening instrument in a private obstetric setting. There have been apprehensions whether self administered questionnaires are suited to the Indian context: being liable for greater nonreporting or biased reporting. In the current study none of the respondents expressed any difficulty or being uncomfortable answering the questionnaire. Further, this study indicates that the probable at risk population is slightly greater than the expected ranges reported by other studies (15-25%).

The current study has revealed an important aspect related to use of EPDS in the Indian context; the Indian English language conversant respondents have differentially interpreted phrases like: 'laugh and see funny side of things', 'looked forward with enjoyment to things' and 'things have been getting on top of me'. These questions intended to capture the sense of hopelessness, low motivation and drive, easy fatiguability, but were not comprehended accordingly. Laugh and see funny side of things were interpreted as understanding a joke, looking forward to enjoyment was equated to going home and feeling comfortable. The idiom things have been getting on top of me', most often, needed to be explained. Thus, this brings to the fore the need for a culture specific English version of the questionnaire. Better still, this implies that the women may find it more comprehensible if the questionnaire was in their mother tongue or in the local language. Hence, there is a need to develop and validate a kannada language (or a local vernacular) version of the questionnaire.

Another important aspect, which needs to be addressed is the health seeking pattern of the individuals (particularly with respect to common mental health disorders). It needs to be acknowledged that helping the mother-to-be to cope better would definitely be a 'value addition' to the existing armamentarium of interventions that is being provided to ensure a comfortable recovery from the antenatal and post natal process. But, it needs to be noted that the respondents did not specifically seek treatment despite reporting problems, for example sleep disturbances. During the one to one interaction

on the subsample, they felt that sleep disturbances and feeling worried are a normal phenomenon during the ante-natal and post-natal process. Towards this end to enhance the abilities of the consultant obstetrician, two of the faculty got themselves trained (RP and another medical graduate) in applying EPDS as a screening tool and clinically managing the patients based on the cutoff scores. The experience gained there from is being reported separately.

## Conclusion

There is a need to validate local language versions of EPDS and explore the simultaneous use of it as a single questionnaire (along with the English language version).

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