

# A qualitative study of the acceptability of routine screening of postnatal women using the Edinburgh Postnatal Depression Scale

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## SUMMARY

**Background:** Screening for postnatal depression using the Edinburgh Postnatal Depression Scale (EPDS) has been widely recommended and implemented in primary care, although little is known about how acceptable it is to women.

**Aim:** To explore the acceptability to women of postnatal screening by health visitors with the EPDS.

**Design of study:** Qualitative interview study.

**Setting:** Postnatal patients from 22 general practices within the area of Oxford City Primary Care Group.

**Method:** Thirty-nine postnatal women from a purposive sample were interviewed, chosen on the basis of different general practices, EPDS results at eight weeks and eight months postnatal, and whether 'listening visits' were received. The interviews were analysed using the constant comparative method.

**Results:** Just over half of the women interviewed found screening with the EPDS less than acceptable, whatever their postnatal emotional health. The main themes identified were problems with the process of screening and, in particular, the venue, the personal intrusion of screening and stigma. The women interviewed had a clear preference for talking about how they felt, rather than filling out a questionnaire.

**Conclusion:** For this sample, routine screening with the EPDS was less than acceptable for the majority of women. This is of concern, as universal screening with the EPDS for the detection of postnatal depression is already recommended and widespread in primary care.

**Keywords:** postnatal depression; women; psychiatric rating scales; interviews.

## Introduction

POSTNATAL depression is a common condition affecting about 13% of women after childbirth.<sup>1</sup> It has significant health implications for the mother, baby, partner and family. Health professionals detect only about 50% of cases of postnatal depression in routine clinical practice.<sup>2</sup> Most cases develop within the first three months,<sup>3</sup> with a peak incidence at four to six weeks.<sup>4</sup> Screening with a self-report questionnaire, the Edinburgh Postnatal Depression Scale (EPDS) can increase the detection of probable postnatal depression;<sup>5</sup> however, a clinical assessment is needed to make the diagnosis.

Screening with the EPDS has been recommended by various authoritative bodies<sup>6,7</sup> and is used in most parts of the country.<sup>8</sup> The English National Service Framework for Mental Health<sup>9</sup> may have accelerated its use.

Current practice is ahead of the evidence base needed for a screening test.<sup>10</sup> In particular, there is no evaluation of the effectiveness of the EPDS in routine clinical practice and there is little evidence about women's experiences of completing the EPDS. Murray and Carothers have judged the questionnaire's acceptability indirectly, with a postal return rate of 97.3%<sup>11</sup> for a sample already recruited to research. In another study, recruited postnatal women were interviewed three months after their final diagnostic interview and they gave largely positive responses about screening.<sup>12</sup>

## Oxford City Postnatal Depression Strategy

A multidisciplinary steering group introduced an Oxford City Postnatal Depression Strategy in April 1994. The background has been described elsewhere.<sup>13</sup> It aimed to improve the detection and management of postnatal depression by routine screening with the EPDS at eight weeks and eight months, at times of existing routine contact with health visitors. These timings are appropriate because by eight weeks the majority of cases of postnatal depression will have developed, and at eight months there is the opportunity to identify both later onset and previously undetected cases of postnatal depression. Subsequent actions, such as non-directive counselling ('listening visits') are based on the screening score and health visitor assessment.<sup>14</sup> The strategy is similar to other reported local strategies.<sup>15,16</sup> Written guidelines, patient materials and training of health visitors underpinned the strategy. The trainers, a consultant psychiatrist (FB) and psychologist, had completed a 'Training the Trainers' course.<sup>17</sup> Initial training consisted of four to six half-day sessions followed by two-monthly supervision. For the

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**HOW THIS FITS IN***What do we know?*

Screening for postnatal depression using the Edinburgh Postnatal Depression Scale (EPDS) has been recommended by authoritative bodies and widely implemented in the United Kingdom.

There is little evidence about the acceptability of screening for postnatal depression for women in routine clinical practice.

*What does this paper add?*

This qualitative interview study found that for this sample of postnatal women screening with the EPDS was less than acceptable for the majority, and this needs further evaluation.



past two years, health visitors have done six to eight hours of personal study using the Marce pack,<sup>18</sup> followed by one day of basic training and subsequent mentoring with an experienced health visitor.

The interview study addressed the question: 'What was the experience for postnatal women of routine screening with the EPDS by their health visitor?'. It formed part of a wider project to evaluate the Oxford City Postnatal Depression Strategy. Information about other aspects of the study have been published elsewhere.<sup>19</sup> This paper explores only the acceptability of screening for postnatal depression.

**Method**

All 32 practices in Oxford City Primary Care Group were invited to participate. Ethical approval was obtained from the Oxfordshire Applied and Qualitative Research Ethics Committee. In total, 26 practices were recruited, of which 22 contributed data: two were unable to take part, and two returned no data.

Health visitors reviewed their files for all mothers of babies born between 1 January 1999 and 30 June 1999. They returned anonymised data on a standard collection form. The data collected were EPDS scores at eight weeks and eight months, listening visits to a woman (defined as 'yes' if at least one visit) and exclusion criteria for the interview study. The exclusion criteria were inadequate spoken or written English, age less than 16 years, learning disability, death of the baby, and transfer in or out of the practice. Ethics approval was not sought to obtain demographic details about the women, as there were concerns that health visitors might have anxieties about this. The data were entered on to SPSS version 10.

One of the researchers (JS) continued to approach women for interview, who were chosen on the basis of their registered general practice, EPDS scores at eight weeks and eight months (a score of 13 or more represents probable depression<sup>5</sup>) and whether listening visits were recorded (a proxy measure for postnatal depression that might have occurred at any time in the first postnatal year, as the health visitor would only record these if she had made a positive diagnosis of postnatal depression), until enough women had been interviewed to reach data saturation. The rationale was to select the most productive sample to answer the research question by including women who had experience

of health visitors from different general practices with a range of socioeconomic populations, and women with diverse experiences of postnatal distress, including depression. The general practitioner (GP) contacted each woman by letter, enclosing a patient invitation and information sheet. The ethical committee required the information sheet to state that the interviewers were a GP and a psychiatrist. If the GP declined to invite the woman then (s)he replied to JS. Six invitations were returned: three of the women had moved, one doctor had objected to sending it, and two doctors had considered the woman too unwell to participate. Interested women returned reply slips to JS and contact was made by telephone. No further attempts were made to recruit non-responders.

*The interviews*

The interviews were in-depth and opened with the question: 'Tell me how you felt in the first three months after your baby was born?'. A topic guide for the interviews, covering broad areas for discussion, was used only if women did not spontaneously raise the issues themselves. It was developed after discussions with five GPs, five health visitors, four midwives and a locum consultant perinatal psychiatrist, and it was developed during the course of the first few interviews to explore emerging themes. If women did not raise the subject of screening they were asked: 'Do you remember being asked to fill out a questionnaire about postnatal depression?' and 'Could you tell me what happened?'. Screening was judged to be 'acceptable' if there was a positive or neutral response to these open-ended questions or previous discourse and 'unacceptable' if there was a spontaneous negative response.

The interviews took place between April and December 2000. Demographic details were obtained by direct questioning before the interview. The interviews were tape-recorded and transcribed verbatim by a professional transcriber. JS checked and anonymised the transcripts. The analysis took place between June 2000 and January 2002. JS, FB and JG read all the transcripts and regularly discussed emerging themes. JG checked the quality of the interviews; for example, that the interviewer was not leading the interviewee or cutting short important topics, and to avoid drifting towards a clinical style of interview. JS and FB made independent assessments of the transcripts to decide if a woman found screening acceptable or unacceptable, but there were no disagreements.

Transcripts were entered on to NUD\*IST qualitative analysis software (version 4) for coding by JS. A coding system was developed after free coding of four transcripts. The analysis was made using the constant comparative method.<sup>20</sup>

**Results**

One hundred and seventy-two women were invited to participate in the interview study. The sampling process is described in Table 1. Thirty-nine women from 17 practices were interviewed, 35 by JS and four by FB. FB interviewed three women known professionally and one socially to JS. Thirty-six women chose to be interviewed at home, two at work and one at JS's workplace. Children were often pre-

Table 1. Sampling process and EPDS scores at eight weeks and eight months, and record of listening visits.

	Whole audit population (n = 781)	Invited for interview (n = 172)	Interviewed (n = 39)
<b>EPDS score at 8 weeks</b>			
No record of score	268	32	7
EPDS 0–12	459	108	24
EPDS ≥ 13	54	32	8
<b>EPDS score at 8 months</b>			
No record of score	351	45	15
EPDS 0–12	389	102	20
EPDS ≥ 13	41	25	4
<b>Listening visits</b>			
No	247	52	15
Not recorded	428	57	11
Yes	106	63	13

sent during the interviews. The interviews ranged in length from 21 to 80 minutes (mean = 52 minutes). Every woman who agreed was interviewed (as appointments had already been made), although data saturation was achieved before the last few interviews. Tables 1 and 2 describe the interview sample. The mean age of the women was 34 years; range = 19 to 42 years. They were interviewed at an average of 15 months postnatal; range = 11 to 19 months. Women with various levels of emotional distress and from different socioeconomic backgrounds were interviewed, but younger women and ethnic minorities were under-represented.

Twenty-one of the 39 women were judged to have found screening unacceptable. Two women reported that they had not been screened at any time. Both of them had deliberately avoided screening, and they had strong negative views about it. The acceptability of screening seemed largely unaffected by measures of postnatal depression (Table 3), although it is possible that more women who did not have listening visits found screening unacceptable. Thirty-four women were screened in the baby clinic and many of them found this unacceptable. The three women screened at home found the experience acceptable. Women's EPDS scores, recorded by health visitors, often did not correspond with their narrative. Women who had found screening acceptable had little to say about it, but the others often spoke at length and with feeling.

There were three major interdependent themes identified to explain the unacceptability of screening: the screening process, the personal intrusion of screening and stigma. The themes are illustrated with quotes from the women.

### The process of screening with the EPDS

Just under half of the women said they felt positive or neutral about completing the EPDS.

*'No. I didn't mind doing that. I mean it was quick, and simple and ... it was nice.'* (Number 15, age 34, first baby, EPDS score 13 at eight weeks, 10 at eight months, listening visits [LV])

*'I did think, gosh, this is good, because it's much easier to do this than to actually look somebody in the face and*

*say, look, I am finding this really difficult to cope. Say look, discover me, please.'* (Number 5, age 32, first baby, EPDS score 8 at eight weeks, 6 at eight months, no LV)

Women who had more negative views found it transparent and simplistic and suggested that they would have preferred open questions or the opportunity to talk.

*'I don't know, I just think they're daft, I mean it's the questions you know, like, have you felt more happy or sad or something.'* (Number 22, age 26, first baby, EPDS score 14 at eight weeks, 17 at eight months, LV)

*'There's so much more that you want to say rather than just answering quite closed questions.'* (Number 24, age 31, second baby, EPDS score 9 at eight weeks, 1 at eight months, no LV)

*'Well a, a lot of things you can, you can tell when somebody's lying, can't you, if you talk to them properly, whereas, you know, as I say, if you were postnatally depressed and really didn't want anybody to know it then you could just lie on the form and there's nothing to say that you were lying.'* (Number 17, age 33, second baby, EPDS score 9 at eight weeks, 4 at eight months, no LV)

*'If I was feeling bad, I'd rather have a coffee and a chat with someone, than put circles round numbers, while the baby's crying.'* (Number 25, age 32, second baby, EPDS score 11 at eight weeks, 5 at eight months, no LV)

Some, but not all, women had been prepared for screening. If they felt poorly prepared, they were anxious about the consequences and reluctant to answer the questions honestly.

*'I was told this was a questionnaire to identify people having problems with postnatal depression and that was it, there was no treatment or no consequences discussed. It wasn't clear to me what would happen if I ticked the bad boxes. I should have been answering it for my own good, and people were trying to help me, but I wanted to get the answers right.'* (Number 3, age 32, first baby, EPDS score 6 at eight weeks, EPDS refused at eight months, no LV)

Thirteen of the women found the baby clinic an inappropriate place to complete the EPDS. The lack of time and privacy, the reluctance to make a fuss and the stress of the clinic were cited as reasons. Most women would have preferred to be screened in their own homes.

*'That first Edinburgh test, to have it filled in and then talked about in front of everybody else was just terrible.'* (Number 37, age 37, third baby, EPDS score 9 at eight weeks, 4 at eight months, LV)

*'When I went to the health centre with all three of them it didn't used to be a good moment really. Just the logis-*

Table 2. Demographic characteristics of the interview sample and subsample who had listening visits (as a proxy measure for postnatal depression).

	Number of women in interview sample (n = 39)	Number of women who had listening visits (n = 13)
Number of children		
1	13	5
2 or more	26	8
Social class (based on woman's occupation)		
I or II	24	8
Other	15	5
Ethnicity		
White	37	13
Other	2	0
Living with father of child		
Yes	35	10
No	4	3
Type of delivery		
Normal	27	10
Ventouse	2	1
Caesarean	10	2

*tics of getting there and then if you'd been waiting, trying to keep them all happy. I guess in that respect if you do it at home maybe you get a fairer result.'* (Number 38, age 30, second baby, not screened with EPDS at eight weeks, score 3 at eight months, LV not recorded)

The attitude of the health visitor and feedback about the results were important to women. About half the women felt listened to.

*'And I was so grateful, and then I just talked to her, and it was so nice to be able to talk freely with her [about the EPDS] at the time.'* (Number 15, age 34, first baby, EPDS score 13 at eight weeks, 10 at eight months, LV)

In contrast, one-third had little feedback and felt dissatisfied. The level of distress was often significant even when a woman was not depressed, and a normal EPDS result could prevent a discussion about troubling symptoms. The women needed the health visitor to take time, and to be professional and empathetic about screening.

*'They [the health visitors] just sort of said, oh, that, that's fine. They said you've got a score of such-and-such, and if you'd been such-and-such we'd have been, what they*

*said they would have done, they would have explored me medically or something. But they said, oh, you're fine. And I remember thinking, oh right, I think I am fine too. But I still feel really miserable because I'm so tired.'* (Number 5, age 32, first baby, EPDS score 8 at eight weeks, 6 at eight months, no LV)

They could sense if the health visitor was short of time or uninterested.

*'I did get the impression [from the health visitors] it's something you've got to do. Let's get it down on the file, and that's another item I can tick off the list of jobs to do.'* (Number 21, age 38, second baby, EPDS score 8 at eight weeks, 7 at eight months, no LV)

Not wanting to let the health visitor down could also be a problem.

*'I didn't want to let them [the health visitors] down either really and so that's why I didn't want to be honest.'* (Number 3, age 32, first baby, EPDS score 6 at eight weeks, EPDS refused at eight months, no LV)

One depressed woman purposely ticked the 'bad boxes', illustrating how the EPDS could be used to communicate distress. Her form was mislaid so she failed to get the response she expected and she was unable to ask for the help she wanted. She was the only woman interviewed who wanted to be picked up by screening.

*'I purposely circled the things 'cos I'm struggling and it felt like the form was just left on the side and nobody picked it up and the health visitor didn't get back to me, which I'm really disappointed about, but I didn't have the courage to ring her up to ask her for help.'* (Number 31, age 38, first baby, EPDS reported as 'refused' at eight weeks and eight months, LV not recorded)

#### Screening seemed a personal intrusion

Some women disliked screening with the EPDS because they felt it was intrusive. They did not feel they were ill and attributed their emotional distress to their social situation. In their view, if there was no medical solution, then it was not a health professional's business to ask intrusive questions; for these women the EPDS seemed pointless and frustrating.

*'I feel it would have been fairly futile [talking to the health visitor] because again there was nothing really she*

Table 3. The acceptability of the EPDS for women, compared with measures of probable postnatal depression (n = 39).

	Listening visits			EPDS score at eight weeks			EPDS score at eight months		
	Yes	No	No record	0-12	≥13	No record	0-12	≥13	No record
Screening acceptable (n = 18)	7	5	6	10	4	4	12	2	4
Screening not acceptable (n = 21)	6	10	5	14	4	3	8	2	11

*could do, I was in a situation, I didn't feel I was unwell, I felt I was in a situation.'* (Number 29, age 32, second baby, EPDS score 1 at eight weeks, refused at eight months, no LV)

*'I remember being frustrated and ticking at the end, fine, fine, fine, or whatever it was, good, good, good, no I'm not depressed. I mean they are not going to give a job to my husband. You don't want a youngster coming in and telling you "Did you take into account this?", it's patronising.'* (Number 18, age 38, second baby, EPDS score 10 at eight weeks, refused at eight months, no LV)

### Stigma

Many women felt that postnatal depression was a stigmatising illness, which they would not or did not want to admit to themselves, or to others. This was intimately connected with their image of being a good mother.<sup>21</sup>

*'Oh well, I think there's plenty, I mean I think there's a huge stigma about feeling depressed particularly postnatal depression and people want to be, not to be thought of as a, you know, not being good mothers.'* (Number 20, age 32, second baby, EPDS score 3 at eight weeks, 2 at eight months, no LV)

Some women covered up the way they were feeling for fear of being 'found out' or having to face the consequences, such as losing their baby, even if this idea was based on inaccurate information from non-professionals.

*'But there's always a face and there's always reality, and you want the face to be that, you know, everything's going well and that you're happy with your baby and your baby's happy and doing all the right things.'* (Number 19, age 32, second baby, EPDS score 4 at eight weeks, 8 at eight months, LV)

*'I didn't trust them I suppose so I didn't tell the health visitors how I was feeling.'* (Number 8, age 37, eighth baby, EPDS score 0 at eight weeks, not screened at eight months, LV not recorded, previous episode of postnatal depression)

*'I was so vulnerable, I believed what she [her mother] said, you know [about the baby being taken away].'* (Number 7, age 19, first baby, EPDS score 10 at eight weeks, 13 at eight months, no LV)

Confronting a mother with a questionnaire to 'diagnose' the stigmatising illness was perceived as threatening, regardless of whether she was depressed. Some women lied deliberately on the questionnaire.

*'I was a bit worried because I thought, "Oh my God, I don't want to land up being depressed." And it's like, and it was really like this, this method defines whether you're depressed or not.'* (Number 19, age 32, second baby, EPDS score 4 at eight weeks, 8 at eight months, LV)

*'When I said I lied on the questionnaire it wasn't hugely dramatic at all, but I think it's obvious from the questions and what the answers should be, if you want to be seen as a good mother.'* (Number 5, age 32, first baby, EPDS score 8 at eight weeks, 6 at eight months, no LV)

*'I think it [lying on the EPDS], it was to prove that I was a good mum and that nothing was wrong.'* (Number 7, age 19, first baby, EPDS score 10 at eight weeks, 13 at eight months, no LV)

### Discussion

Just over half of the women in this community study found screening with the EPDS less than acceptable, regardless of their postnatal emotional health; this was unexpected by the researchers. Postnatal women considered, answered and experienced the EPDS in complex and unpredictable ways. The inadequacy of preparation and feedback from screening, the environment of the baby clinic and lack of time were particularly important in creating difficulties for women. Many reported giving deliberately unreliable responses. Women expressed a clear preference for talking about how they were feeling, rather than ticking boxes. There is no similar published study.

This study has limitations. The interviews were carried out some time after the last time of scoring. However, women appear to remember the circumstances and details of their postnatal experience accurately for many years,<sup>22,23</sup> even if they have been depressed. The study did not include a 'gold-standard' assessment of postnatal depression, although classifying EPDS scores into two categories: 12 or less, and 13 or more, and receiving listening visits, is likely to have produced a sample representative of a spectrum of emotional distress after childbirth. However, there may have been women who preferred to talk, rather than filling out forms. Young, single women, those from lower socioeconomic groups, and women from ethnic minorities, who were under-represented in the sample, may have been reluctant to be involved, because they knew that both interviewers were doctors.<sup>24,25</sup>

Additional training and resources could make the process of screening more acceptable to women. A recent study has suggested that: 'even magic wands can be dangerous in untrained hands'.<sup>26</sup> Extensive training of health visitors in a research setting has led to improved outcomes for women.<sup>27</sup> However, the training in Oxford is as good as possible within the available resources, and is probably at least as good as the training in many other places. The extra human and financial resources that would be needed for informed consent and to give privacy and time for screening, as suggested by this research, seem unlikely to be forthcoming either locally or nationally within the current constraints of the health service.

Better training and attention to all the process issues identified in this study could also help to avoid the personal intrusion and stigma that reduced the acceptability of screening. However, stigma about depression is a big issue for women, of which health professionals need to be aware. Goffman has described stigmatising illnesses where an individual thinks she is not 'normal', making her uncertain and fearful

of the response of family, friends and health professionals.<sup>28</sup> This theory could explain why a depressed postnatal woman confronted with the EPDS has trouble deciding whether, in Goffman's words: 'To display or not to display; to tell or not to tell; to lie or not to lie; and in each case to whom, how, when and where'.

### Practical issues

This study suggests that, by screening in private (preferably at home), by reassuring a woman about the consequences of disclosure, and by optimising the communication skills of health visitors, more women might feel secure enough to disclose their distress.

Health visitors have an important role in detecting, supporting and managing women with postnatal depression, whether or not they use the EPDS, but they need to be supported with adequate resources and training. Training should focus on communication and listening skills as well as on scoring the EPDS.

### Research issues

This study demonstrates that the EPDS needs to be properly evaluated in routine clinical practice. In addition, the cost effectiveness and acceptability of screening with the EPDS need to be compared with an alternative, such as asking postnatal women for a simple yes/no answer about whether they would like to discuss their feelings with someone, or to use the EPDS as an unscored tool to give health visitors confidence to 'open up' discussions about postnatal depression, rather than being used as a substitute for talking.

### Conclusion

This study has shown that, for this sample, routine screening was less acceptable than expected from previous research studies. Further research is needed to explore the issues raised by these results, as universal screening with the EPDS for the detection of postnatal depression is already recommended and widespread in primary care.

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