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CORRESPONDENCE

EVALUATION OF POSTPARTUM DEPRESSION USING THE EDINBURGH POSTNATAL DEPRESSION SCALE IN EVALUATION OF POSTPARTUM DEPRESSION IN A RURAL COMMUNITY IN INDIA

Sir,

Postpartum depression has been extensively studied in the West, but has received little attention in our country. We sought to study the feasibility of adapting and using the Edinburgh Postnatal Depression Scale (EPDS), a self-administered screening instrument, in our setting (Cox, 1987). Our postpartum women differ from those for whom the EPDS was originally designed in several ways. A significant number are illiterate, hence a self-administered scale will have limited applicability. Specialised psychiatric care is virtually nonexistent in the periphery. Hence, the physician handling the woman's antenatal care and delivery will also have to assess her for postpartum depression.

We modified the scale with these considerations in mind. The scale was translated into Hindi, the instructions were adapted to allow the scale to be interviewer-administered, and the choices were presented as four grades of frequency at which the symptom was experienced.

The study was conducted at a rural hospital in Haryana, North India. The EPDS was administered six weeks after delivery. No 'gold standard' assessment for depression was included in the study design. The mothers' ability to breastfeed and care for the baby was taken as an indicator of her functional status. It was expected that a depressed mother would be unable to cope with these demanding tasks adequately, and would need assistance in them.

Thirteen women completed the study. Their mean age was 23.2 years; six were primiparous. Significant difficulties were experienced in administering the EPDS. The mothers could not comprehend the items on sense of humour, optimism, guilt, and ability to cope, which require introspection into one's responses to specific types of situations. In contrast, direct questions on their feelings of anxiety, fearfulness, unhappiness, misery, tearfulness, and thoughts of self-harm elicited prompt and confident replies.

They seemed unable to focus exclusively on their subjective experience, and did not stick to the format of selecting one of the offered choices as their response. Instead, they used the questions as openings to discuss their family circumstances, concentrating on their husband, in-laws and baby. These observations raised serious doubts about the value of the data collected.

Six (46%) women had EPDS scores of 9 or more; three (23%) scored 12 or more. The highest score of 20 was that of a mother whose baby died soon after birth. The babies of all the other five mothers whose scores were above 9 were exclusively breastfed, and were being fully taken care of by their mothers. The fully functional status of all the women scoring

higher than the cutoff threshold on the EPDS argues strongly against these elevated scores being indicative of clinically significant depression in our sample.

Our findings suggest that several factors peculiar to our setting diminish the acceptability of an EPDS-like approach. An alternative approach to elicit the relevant symptoms could be an open-ended discussion centered around their family, with probes at appropriate junctures regarding negative feeling states and ability to function adequately in the new role.

REFERENCE

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