

uncontrollable for parents. Its unsoothability seems to be what most sets it apart.

BOX 1:

Features of the crying of one to three month old infants which underlie Western parents' concerns:

Prolonged bout length;
Relatively high crying intensity (high cry:fuss ratio);
Unexplained/unpredictable - no apparent reason;
Unsoothability.

Do some babies have gastro-intestinal pain?

The third assumption of the traditional view is that the crying is due to gastro-intestinal disturbance and pain. This idea has fared better, in that recent paediatric reviews have concluded that up to 10% of one to three month old babies presented for problem crying do have organic disturbances, including cows' milk protein intolerance. Clearly, it is important for practitioners to be able to distinguish these cases. But, they should expect them to be rare. On the best evidence, some 90% of cases do not have organic disturbances. How, then, are these - the overwhelming majority - to be explained?

One claim advanced in the 1990s was that the crying was due to inadequate parental care. This, too, is probably a factor in occasional cases, but unlikely to explain many. Studies employing trained observers in the home have found parents of high criers to be highly responsive and sensitive, while their babies were difficult for even experienced midwives to soothe. This does not take baby-care out of the picture completely - since one outstanding question is whether methods of baby care beyond what is normal in Western societies would reduce babies' crying. What the existing findings do imply is that babies who cry a lot in the first three months do so in spite of care that is effective for most Western babies.

This suggests that differences in how much infants cry during this early period are probably due to individual differences in babies' dispositions. This is currently the leading hypothesis and a good deal of evidence has accumulated to support it. For example, infants who cry a lot at home have been found to be poor at regulating their responses to stressful stimulation, such as standard baby exams. A change in how the central nervous system regulates behaviour takes place at this early age, and it looks increasingly that this holds the key to the puzzle of unexplained crying in one to three month old babies. Much remains to be discovered, but this approach allies with the shift of focus from pathology to development, and gut to nervous system, which has characterised recent research.

PRACTICAL IMPLICATIONS OF THESE RESEARCH FINDINGS

Elements of an evidence based protocol for clinical management

1. Because the presenting phenomenon is parent complaint

about infant crying, accurate assessment of actual infant behaviour is a vital first step. A behaviour diary can be used to measure the crying amount, pattern and nature, and provide parents with reassurance and insight.

2. Collection of information to identify any maternal depression, extent of social support, and other sources of vulnerability should also be a core part of the primary work.

3. Practitioners need inclusion / exclusion criteria for identifying "organic cases". Gormally and Treem propose screening for the following "Red Flags":

- high pitched/ abnormal sounding cry;
- lack of a diurnal rhythm;
- presence of frequent regurgitations, vomiting, diarrhoea, blood in stools, weight loss or failure to thrive;
- positive family history of migraine, asthma, atopy, eczema;
- maternal drug ingestion;
- positive physical exam (including eyes, palpation of large bones, neuro, GI and cardiovascular assessment);
- persistence past four months of age.

4. Once the possibility of organic disturbance has been ruled out and the infant's healthy growth and development has been confirmed, the focus for management should shift to providing parents with information, advice and support. Important elements are likely to be:

- Examining the notion that crying means that there is something "wrong" with a baby of this age and introducing alternatives - such as the possibility that it signals a reactive or vigorous baby.
- Viewing the first three months of infancy as a developmental transition, which all babies go through more or less smoothly.
- Reassuring parents that it is normal to find crying aversive and discussing the dangers of abuse and "shaken baby syndrome".
- Discussing ways of containing and minimising the crying, and highlighting positive features of the baby.
- Considering the availability of supports and the development of coping strategies which allow parents to "recharge their batteries".
- Empowering parents and reframing the first three months as a challenge which they can overcome, with positive consequences for themselves and their relationships with their babies.
- Continuing to monitor infant and parents.

FURTHER INFORMATION

Ian St James-Roberts will email copies of the PowerPoint slides and references included in his RSM talk; his email address is i.stjamesroberts@ioe.ac.uk

NCT EVIDENCE BASED BRIEFING Depression Before & After Childbirth

*"Postnatal depression tears the fabric of a woman's self-esteem, her marital relationship, and her relationship with her children. It can be particularly devastating at a time when the woman and her family expect joy and happiness to be the rule of the day, not sadness and depression."*¹

Murray and Cooper, 1997.

INTRODUCTION

This briefing covers the causes and effects of depression in pregnancy and after childbirth. It introduces theoretical approaches to the understanding and treatment of postnatal depression, examines the effectiveness of the Edinburgh Postnatal Depression Scale (EPDS) as a method of screening, and highlights key aspects of effective care.

BACKGROUND: DEPRESSION & CHILDBEARING

Mental and behavioural disorders affect individuals of every nationality, age group and social background. The World Health Organisation currently estimates that some 450 million people suffer from a mental or behavioural disorder. Depression, in particular, is experienced by half of all women and a quarter of all men at some time during their lives. Second only to heart disease, depression is moreover predicted to become the greatest cause of premature death and disability worldwide, by 2020.²

Mental illnesses associated with childbirth, including both new episodes as well as recurrences of pre-existing conditions, are also common. As part of the normal process of adjustment to pregnancy and motherhood, all women experience physical changes together with a range of different emotions both before and after giving birth. Throughout the antenatal and postnatal periods, however, several mood disorders may develop, including antenatal depression, maternity blues, postnatal depression and puerperal psychosis.

● **Antenatal depression:** although it is still not sufficiently recognised, depression is as common antenatally as postnatally.³ Characterised by feelings of anxiety, sadness and low self-esteem, antenatal depression may become apparent at any time during pregnancy. Evidence suggests that approximately two-thirds of women with postnatal depression had already been depressed antenatally; with only about three percent of women having a first-time depression after delivery.⁴

● **Maternity blues:** is the most common, mild and short-lived mood disorder affecting about half of all mothers and characterised by anxiety, restlessness and tearfulness. Primarily connected to childbirth-related hormonal fluctuations, it tends to peak between the third and fifth postnatal days.⁵

● **Postnatal depression (PND):** is a very common non-psychotic depressive episode, usually affecting between 10 to 15 percent of mothers. Beginning in, or extending into, the postpartum period, PND is characterised by irritability, anger, low energy levels, general loss of interest and feelings of guilt.⁶

● **Puerperal psychosis:** is a very rare and serious disorder occurring after about one in 500 births. This potentially long-term mental illness causes severely disturbed mood and behaviour, featuring hallucinations and loss of contact with reality. With a significant risk of suicide and infanticide, admission to hospital for psychiatric treatment may be needed for up to two years.⁷

The Royal College of Obstetricians and Gynaecologists' **Report of the Confidential Enquiry into Maternal Deaths (CEMD)** in Britain indicates that deaths from suicide are not only the leading cause of indirect death, but also the leading cause of maternal deaths overall.⁸ Of those women who suffer from a depressive condition, between one-third and one-half are known to experience a severe depressive illness. Psychiatric disorders such as PND, in particular, are known to have caused or contributed to 12 percent of the 11.4 deaths per 100,000 maternities in the country.⁹

THE EFFECTS OF DEPRESSION ON THE MOTHER, CHILD & FATHER

Not only are childbirth-related depressive conditions a widespread phenomenon, but they also place an enormous burden on the individuals directly or indirectly affected by them. PND, in particular, can have a significantly detrimental effect on the health, social and emotional wellbeing of the mother, her baby and partner, as well as other family members.¹⁰ Scientific literature has nonetheless tended to overlook women and men's experiences of early parenthood and feelings of depression.¹¹

PARENTS' EXPERIENCES

In an NCT national survey, women who felt anxious, depressed or unhappy suggested that some of the associated factors were lack of sleep, problems with the baby's health, isolation, and difficulties with their partners.¹² Studies of fathers' experiences both of preparation for childbirth and transition to fatherhood have furthermore highlighted a gap between their needs and the services available to them.^{13,14} Within the UK, fathers have reported wanting more support and information about their role as fathers, coping with a crying baby, and PND.¹⁵

EFFECTS ON THE BABY

There is little evidence available on the effects of severe depression on the developing child. However, research shows that antenatal depression, and especially anxiety (they frequently occur together) appears to affect the fetus in a way that leads to long-term behavioural problems in the child.¹⁶

Hedegaard and colleagues furthermore found that the risk of preterm delivery was related to the extent of psychological distress women experience in late pregnancy, with a higher risk for those experiencing higher levels of distress.¹⁷ Another study of women experiencing severe emotional stress in early pregnancy, due to the unexpected death or life-threatening illness of an older child or partner, showed an increased risk of congenital malformations, particularly of the cranial-neural-crest.¹⁸

After birth, PND is known to have a negative effect on the mother/baby interaction.¹⁹ Evidence suggests that children of postnatally depressed mothers are significantly less likely to develop close attachments with them than those of mothers who had been well in the postnatal period.²⁰ Studies of clinically depressed mothers have furthermore shown that their infants' emotional development often becomes impaired; with such children reporting behavioural problems, including sleeping and eating difficulties as well as temper tantrums.^{21,22}

Exposure to maternal depression in the early postpartum months not only affects infants, but it may also have lasting psychological effects on children later in life. Murray and colleagues' longitudinal study of the development of children of depressed mothers up to the age of five showed that their behaviour and psychological adjustment was adversely affected by the mothers' condition.²³ Although the risk of developing serious mental illness is small, children of depressed mothers nevertheless experienced significantly more behavioural problems, cognitive impairment and difficulties with interaction. Within the school setting, in particular, children whose mothers suffer from depression have been found to display more hyperactive and disruptive behaviour.²⁴ Significantly, there is evidence that the effects of antenatal anxiety on the long-term behaviour and emotional development of the child are of a similar magnitude to those of PND.²⁵

RELATIONSHIPS WITH PARTNERS

Postnatally depressed women also have more difficulties in their relationships with their partners. In a longitudinal study of depression in couples before and after the birth of a first child, Areias and colleagues found that depression in fathers was associated both with a personal history of depression as well as with their wives or partners being depressed during pregnancy and soon after delivery.²⁶

A further study exploring the emotional experiences of couples during the postpartum period revealed that depressive symptoms were positively correlated between parents.²⁷ Webster has argued that it is no longer acceptable for health professionals to consider the woman in isolation, as partners of depressed women may be feeling depressed and being in need of support themselves. As Webster put it: "fathers have the right to have a voice and be listened to. It would appear that for too long the issues surrounding men during the transition to parenthood have been neglected".²⁸

Despite the magnitude of PND as a mental health problem, only a minority of those suffering from it actually seeks or receives adequate postnatal care treatment.

THEORETICAL APPROACHES TO THE TREATMENT OF PND

PND is believed to be the result of a combination of physical,

psychological and social circumstances. The arrival of a new baby in the family may often be accompanied by a number of stressful changes such as lack of sleep, financial worries, leaving employment, reduced leisure and social activities, as well as marital problems. Systematic reviews have identified specific PND-related risk factors such as personal history of depression, unstable marital relationship, as well as inadequate medical, social and financial support.²⁹

As knowledge of PND has progressively developed, so have explanations of why some women become depressed after birth. The focus and emphasis have fluctuated from concern with physical and biological factors such as hormonal changes, to social circumstances such as childbirth-related stress. Most recently, emphasis has shifted from the causes of PND to its impact on both mother and child.³⁰ Perspectives on PND can be broadly classified into two categories: the medical and social models:

- **The medical model** has traditionally dominated health care practice. Within this framework, PND is generally understood as a biological response to hormonal imbalances following pregnancy, childbirth and lactation.³¹ Prescription of antidepressant medication, as well as hormonal and occasionally electro-convulsive therapies have tended to be recommended as preferred treatments.³²
- **The social model** focuses on psychological and social factors that affect childbearing women.³³ PND is explained as an emotional response to the stressful life-changing event of childbirth, the loss of previous status and professional and personal roles, isolation and lack of social support.^{34,35} The social model tends to promote the need for social support and the use of psychological treatments such as psychotherapy, individual counselling and family and group therapies.³⁶ Nicolson's longitudinal study of clinically depressed mothers has provided a radical critique of the conventional medical explanation of PND as an illness. The study presents women's feelings of depression through unfulfilling experiences of motherhood: depression is seen as a grieving reaction from the loss of one identity to another.³⁷

SCREENING TOOLS

The variability in presentation and symptoms of PND makes it a difficult condition to diagnose, with various different assessment strategies having been tried. Both the Beck Depression Inventory (BDI) and the General Health Questionnaire (GHQ) were developed as measurements for use in all types of depression. As a result, they have proved unreliable for the identification of PND.³⁸

The Edinburgh Postnatal Depression Scale (EPDS), in contrast, was specifically designed to enable screening of large numbers of women, who had recently given birth. It measures the severity of some symptoms of childbirth-related depression. This self-rating scale, administered by health visitors, comprises ten statements with multiple possible responses. Women with high scores above the established cut-off of 12-13 (lowest severity of symptoms scoring zero, and greatest severity scoring 30) would subsequently be referred to a health professional for a detailed assessment of their needs, including a standardised diagnostic interview.

The EPDS has become a widely used method of screening for PND among health professionals in primary care; for there is evidence that validates it as a reliable tool both during

pregnancy and postnatally.^{39,40} Concern has nevertheless been progressively growing about the reliability of the EPDS.^{41,42} Some studies, for instance, have shown that the EPDS does not exclusively measure depression, but it also detects anxiety symptoms.⁴³

Sheelah Seeley, Winnicott Research Unit, speaking at the Community Practitioners and Health Visitors Association's **Postnatal Depression and Maternal Mental Health 2001 Conference**, also indicated that the use of cut-off scores, which exclude clinical judgement, might result in false positives and false negatives. As a result, some women who should be referred for clinical assessment may not be, while others, who the visitors did not deem to be at high risk, may be referred. Seeley pointed to additional problems with the EPDS such as the possibility of women misunderstanding and/or misreading the questions. Seeley concluded by saying that "the scale is only as good as the person interpreting it. Where there is no, or inadequate, training individual health visitors will use it as best as they can, but this may not be good enough".⁴⁴

Early results of **The Oxford City Postnatal Depression Strategy: Audit and Women's View Study** highlight the widespread lack of attention given to exploring women's views on the screening process.⁴⁵ Based on women's experiences of screening after childbirth and their need for support, the study shows that many women are ashamed about feeling depressed and reluctant to seek professional help.

EVIDENCE OF EFFECTIVE CARE

The Scottish Intercollegiate Guidelines Network (SIGN) recently published evidence-based guidelines on PND and puerperal psychosis for use by health professionals.⁴⁶ The guidelines use a grading system to distinguish between different levels of evidence and the strength of the evidence on which each recommendation is based. They can be accessed at www.sign.co.uk Some key points are presented here:

Risk factors for PND and puerperal psychosis

- Procedures should be in place to ensure that all women are routinely assessed during the antenatal period for a history of depression.
- Pregnant women and their partners should be given information during the antenatal period on the nature of postnatal mood disorders and puerperal psychosis.

Antenatal screening for PND

- All women should be screened during pregnancy for previous puerperal psychosis, history of other psychopathology (especially affective psychosis) and family history of affective psychosis.
- Women with positive risk factors for puerperal psychosis should receive specialist psychiatric assessment antenatally.

PND screening

- The EPDS should be offered to women in the postnatal period as part of a screening programme for postnatal depression.
- The EPDS is not a diagnostic tool. Diagnosis of postnatal depression requires clinical evaluation.

- A cut-off on the EPDS of ten or above is suggested for whole population screening.
- The EPDS should be used at approximately six weeks and three months following delivery and should be administered by trained health visitors or other health professionals.

Management of PND and puerperal psychosis

- Postnatal depression and puerperal psychosis should be treated.
- St John's Wort and other alternative medicines should not be used during pregnancy and lactation until further evidence as to their safety in these situations is available.
- The use of hormonal therapies in the routine management of patients with PND is not advised.
- Puerperal psychosis should be managed in the same way as psychotic disorders at any other time, but with the additional considerations regarding the use of drug treatments when breastfeeding and in pregnancy.
- The psychosocial treatment option chosen should reflect both clinical judgement and the mother's and family's preferences where possible.

Prescribing issues in pregnancy and lactation

The following general principles governing prescription of new medication or the continuation of established therapy during pregnancy and breastfeeding apply to all the recommendations:

- Establish clear indication for drug treatment (i.e. the presence of significant illness in the absence of acceptable or effective alternatives).
- Use treatments in the lowest effective dose for the shortest period necessary.
- Drugs with a better evidence base (generally more established drugs) are preferable.
- Assess the benefit/risk of the illness and treatment for both mother and baby/tetus.⁴⁷

Overall, the guidelines seem to promote a holistic approach to the treatment of PND and puerperal psychosis, involving the use of a wide range of different intervention options, thus: "effective detection and adequate management of these disorders requires co-ordination of a wide variety of primary and secondary care services, including midwives, health visitors, clinical psychologists, community psychiatric services, general practitioners, pharmacists, obstetricians and psychiatrists, with other community agencies, such as voluntary sector organisations and social services providing further support".⁴⁸

Studies suggest that the use of a wide range of social and community-based interventions is beneficial to mothers' wellbeing. Ray and Hodnett's review of **Caregiver Support for Postpartum Depression** shows that the availability both of professional and social support for mothers may help in the treatment of PND. Just as healthy women benefit from social and emotional support during and after labour, this seems also to be the case for clinically depressed mothers.⁴⁹ The Royal College of Paediatrics and Child Health (RCPCH) has furthermore indicated that home-based psychological support programmes delivered on a weekly basis for six to ten weeks are effective in bringing about remission from depression.⁵⁰ The key ingredient of these programmes is the provision of committed emotional support to parents. Appropriate support not only helps relieve depression, but it is likely to benefit the mother-child relationship.

The National Service Framework (NSF) on Mental Health for England, which sets national standards of good practice and defines service models for the treatment of mental illness, advocates an integrated approach to the management of PND. The NSF recommends that health and social services should promote "mental health for all", individuals as well as communities.⁵¹ In order to improve clinical outcomes, the NSF envisages "developing research tools with services users to assess their views on how services can best meet their needs".⁵² In addition to maximising service user involvement in clinical practice, the NSF makes recommendations regarding combating "discrimination against individuals and groups with mental health problems" as well as promoting their "social inclusion".⁵³

KEY POINTS

Depression both before and after childbirth is a major health problem concerning a significant number of women worldwide. Evidence indicates that PND adversely affects women and has a considerable impact on their children, partners and families.

Despite the seriousness of this health and social problem, PND is frequently overlooked by health professionals and misunderstood in the community. In particular, the views and needs of clinically depressed mothers, their partners and families have been largely neglected.

There is currently a considerable emphasis on screening for PND, and the EPDS has become widely accepted as a useful screening tool; only to be used as part of a programme for assessing which women need additional support or treatment.

Evidence-based clinical guidelines, developed for Scotland, are now available. These guidelines together with the NSF on Mental Health for England have recommended the provision of information and support services for parents throughout pregnancy, childbirth and in the postpartum period. Where it is available, home-based assessment and psychological support for women with PND offer the potential benefit of responding to the needs of the mother, her child and partner.

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The full version of the Current Awareness Bulletin (on which Research Roundup is based) is available online from http://groups.yahoo.com/group/nct_research/

CHILD

Neonatal Health

Ref ID 673 - Wolke D, Dave S, Hayes J, Townsend J, Tomlin M. A randomised controlled trial of maternal satisfaction with the routine examination of the newborn baby at three months post birth. *Midwifery* 2002; 18(2): 145-154.

Objective: to determine whether any differences in maternal satisfaction with the examination of a newborn baby between midwives and junior paediatricians are maintained over a three month period. Findings: high satisfaction with the examination was reported by most mothers (day one: 82%; three months: 79%). At day one, mothers whose babies were examined by a midwife were more satisfied with the examination (crude odds ratio (OR) for the lowest tertile of satisfaction 0.49, 95% CI 0.32-0.73). However, after controlling for provision of health education during the examination (e.g. discussing feeding, sleeping and skin care) and continuity of care provided, maternal satisfaction was no longer related to status of examiner (adjusted OR 0.83, 95% CI 0.52-1.33). Three months later, there was no significant difference in maternal satisfaction with midwife and junior paediatrician examinations of the newborn baby (crude OR 0.89, 95% CI 0.58-1.37). Discussion of health-care issues by the examiner during the examination was significantly related to increased satisfaction even at three months. Three month ratings of low satisfaction with the examination were most strongly predicted by current maternal depressive mood, even when other factors were adjusted for (adjusted OR 2.58, 95% CI 1.19-5.59).

FEEDING

Breastfeeding

Ref ID 513 - Dennis CL. Breastfeeding peer support: maternal and volunteer perceptions from a randomised controlled trial. *Birth* 2002; 29(3): 169-176.

Several studies have demonstrated the positive effects of peer support on various breastfeeding outcomes, but no study has assessed women's and peer volunteers' views on, or the nature and intensity of, the supportive intervention. The objective of this study was to describe maternal and peer volunteer perceptions of their experience while participating in a breastfeeding peer support trial. A randomised controlled trial was conducted to evaluate the effect of telephone-based peer (mother-to-mother) support on breastfeeding duration. Two hundred and fifty-six primiparous breastfeeding women were randomly allocated to receive either conventional care or conventional care plus peer support. Three primary outcome measures were peer volunteer activity logs, maternal perceptions of peer support, and evaluations of the peer volunteer experience. Conclusions: Both mothers and peer volunteers perceived their intervention experiences positively. Whereas maternal satisfaction was related to the number and duration of peer volunteer contacts, peer volunteers enjoyed their training session and the opportunity to assist mothers for a variety of reasons. Specific intervention modifications should be implemented to enhance peer volunteer satisfaction and retention. [Author]

Ref ID 515 - Sachs L, Oddie S. Breastfeeding - weighing in the balance: reappraising the role of weighing babies in the early days. *MIDIRS Midwifery Digest* 2002; 12(3): 296-300.

This review considers the literature on breastfeeding and the incidence of hypernatraemic dehydration; it discusses how midwives might respond by concentrating on the early

initiation of breastfeeding and understanding its normal processes. [Author]

Education

Ref ID 677 - Ingram J, Johnson D, Greenwood R. *Breastfeeding in Bristol: teaching good positioning, and support from fathers and families. Midwifery 2002; 18(2): 87-101.*

Objectives: to determine whether a specific "hands-off" breastfeeding technique, based on the physiology of suckling and clinical experience, if taught to mothers in the immediate postnatal period, improves their chances of breastfeeding successfully and reduces the incidence of problems. To investigate the factors associated with breastfeeding at two and six weeks postpartum using logistic regression analysis. Conclusions: in the immediate postnatal period, if mothers are taught good breastfeeding technique by midwives in a "hands-off" style, which enables mothers to position and attach their babies for themselves, and which is based on a physiological approach, breastfeeding rates are increased and the incidence of perceived milk insufficiency decreases. Successful breastfeeding in the early weeks was associated both with practices and support in hospital and with factors at home including not using dummies and having a supportive partner, family and health professionals who are encouraging breastfeeding.

LABOUR

Alternative/Complementary

Ref ID 522 - Burns E. *Aromatherapy in childbirth. MIDIRS Midwifery Digest 2002; 12(3): 349-353.*

An overview of a prospective observational study to investigate the potential of the application of aromatherapy to women during childbirth is presented. The sample included 8000 mothers over an eight-year period. Comparison data from women in the same maternity unit who did not use essential oils are used to demonstrate differences in uptake of epidural anaesthesia. Findings suggest that women who used aromatherapy were less likely to go on to use epidural anaesthesia, irrespective of parity and labour onset. Women consistently rated the experience of receiving aromatherapy to be positive, and the study reported only a small proportion of non-mutually exclusive associated symptoms following the administration of essential oils. Aromatherapy was not found to be an expensive choice for women in childbirth. [Author]

Breech

Ref ID 551 - van Roosmalen J, Rosendale F. *There is still room for disagreement about vaginal delivery of breech infants at term. British Journal of Obstetrics and Gynaecology 2002; 109(9): 967-969.*

This commentary criticises the methodology of the Term Breech Trial. The inclusion of some cases that added to the negative results of vaginal delivery is questioned, as is the short follow up period for maternal morbidity. [LG]

Caesarean

Ref ID 575 - Young TK, Woodmansee B. *Factors that are associated with Caesarean delivery in a large private practice: The importance of pre-pregnancy body mass index and weight gain. American J Obstetrics and Gynaecology 2002; 187(2): 312-320.*

Objective: The purpose of this study was to examine body mass index and pregnancy weight gain as risk factors for primary Caesarean delivery in nulliparous women in a middle-class private practice. Results: The overall Caesarean delivery rate for primiparous women was 21.76%. Risk of Caesarean

delivery increased consistently and significantly ($P < .0001$) with increasing body mass index. This effect was primarily mediated through an increase in Caesarean delivery carried out for cephalopelvic disproportion/failure to progress. In our practice, the primiparous woman whose body mass index is >30 kg/m² is six times more likely to have a Caesarean delivery for the diagnosis of cephalopelvic disproportion/failure to progress than the primiparous woman whose body mass index is <20 kg/m². This differential in Caesarean delivery rate persisted when controlled for birth weight and gestational age and continues to persist when maternal age and height are also controlled. Excessive pregnancy weight gain exerted a statistically significant effect on Caesarean delivery rate. This increase was primarily related to cephalopelvic disproportion/failure to progress among the non-obese women.

Ref ID 525 - Wagner W. *Critique of the British RCOG National Sentinel Caesarean Section Audit Report of Oct 2001. MIDIRS Midwifery Digest 2002; 12(3): 306-370.*

This audit represents an important recognition on the part of RCOG that a rising rate of Caesarean section (CS) is worrisome. Important data are generated and the beginnings of a medical evaluation of the results made. A closer look at the report is a window into the obstetric approach to childbirth in England and Wales. Completing the audit is an important step but a careful critique of the audit reveals several problems. The audit gives little account to the social factors contributing to CS rates; whilst litigation is mentioned briefly, there is no data on this issue; convenience - there is no analysis of birth by day of the week; the report does not separate out and record planned home birth. No mention is made in the audit report of the considerable costs of the rising CS rate. The author points out that obstetricians are looking for something to go wrong unlike midwives and that interventions can cascade leading to CS. Obstetrician factors and midwifery factors are considered and the report acknowledges the importance of one-to-one midwifery care in lowering CS rates.

Choice

Ref ID 529 - Anderson T. *The misleading myth of choice: the continuing oppression of women in childbirth. MIDIRS Midwifery Digest 2002; 12(3): 405-407.*

The author questions how much true choice there is when, having made an informed choice, that choice is denied. The author feels that the full power and control of women in childbirth still resides unequivocally within the patriarchal, bureaucratic, obstetrician institution. A humanistic charter for change to woman-centred individualistic maternity, as outlined in **Changing Childbirth**, is not possible without challenging the ruling hegemony and is doomed to failure. The NHS emphasises standardisation of care pathways rather than an individualised approach; the supremacy of technology overshadows women's voices; and bureaucracy and fear of litigation tramples trample their wishes and dreams. Care remains firmly institution-centred and concerned for administrative convenience, whilst the wishes of the woman are an irritation. The only people whose interests are served by perpetuating the danger/risk model of childbirth are obstetricians and obstetric anaesthetists. One of the major restrictive features of the technocratic paradigm of health care is its intolerance of other ways of thinking. As far as the obstetric team are concerned there is nothing to discuss; there is no alternative. Very little has changed since **Changing Childbirth**. [LG]

Onset

Ref ID 682 - Burvill S. *Midwifery diagnosis of labour onset.*

British Journal of Midwifery. 2002; 10(10): 600-605.

The premise of this study was that midwifery diagnostic cues have been subsumed by the biomedical approach. The purpose of this qualitative study was to find out how midwives diagnose labour onset and create a model of that knowledge. Two approaches for data collection were used: A preliminary midwife focus group and a series of in-depth interviews with an expert midwife. The focus group generated themes and concepts leading to a three part conceptual framework: physiological, socio-philosophical and psychological. The main findings were that midwives use a variety of emotional, psychological, and physical cues to diagnose the labour onset. The overall "tendency" for labour onset is described as "increasing inward focus", reflected in cues such as movements, breathing, conversation, and emotional states. The recognition and use of these cues is influenced by the political and social context in which the midwife works. The final model demonstrates how midwives can work with women outside the biomedical paradigm. It is hoped that this research will contribute to a midwifery discourse surrounding labour onset care. [Author]

Pain Relief

Ref ID 524 - Hunt S. *Pethidine: love it or hate it? MIDIRS Midwifery Digest 2002; 12(3): 363-365.*

This article explores the author's conflicting attitude to the administration of pethidine in labour. It seeks to find evidence that pethidine is an effective analgesic and has positive benefits on the progress of labour, as suggested by the anecdotal evidence from midwives. Research into the negative effects of pethidine in labour on the baby and breastfeeding is also examined. The literature cited concludes that pethidine is a sedative rather than an analgesic and may have considerable negative side effects on the mother. No evidence was found to support the suggestion that pethidine might shorten labour. There is much evidence regarding the negative effects of pethidine administration in labour on breastfeeding. Babies show altered pre-feeding and feeding behaviour in both the immediate and later neonatal period that may delay the initiation of breastfeeding. The article concludes by suggesting that midwives should be fully aware of the side effects of giving pethidine to mother and baby and should ensure that women are making fully informed choices. Mothers who do use pethidine in labour should be offered extra support with breastfeeding, including being taught hand expression and learning to recognise the babies' feeding cues. [Author]

Perineal Injury

Ref ID 526 - Steen M. *A randomised controlled trial to evaluate the effectiveness of localised cooling treatments in alleviating perineal trauma: the APT Study. MIDIRS Midwifery Digest 2002; 12(3): 373-376.*

Approximately 40% of primiparous women and 20% of multiparous women sustain some degree of perineal injury. The pain associated with the wound or its repair has been reported as traumatic. The application of cooling treatments has been used for centuries and it is acknowledged that cooling can produce strong analgesic effects. This paper reports the preliminary findings of a clinical trial to compare the effectiveness of cooling gel pads with ice packs and no localised treatment over a period of time up to 14 days. [LG]

MATERNITY SERVICES

Birth Centres

Ref ID 561 - Page L. *Building for a better birth. British Journal of Midwifery 2002; 10(9): 536-538.*

The principles involved in building a birth centre - room to move, furniture to assist movement and best positioning, a quiet homely space and preparing midwives who are confident in the support of physiologically active labour and birth. [LG]

Choices

Ref ID 674 - O'Cathain A, Thomas K, Walters SJ, Nicholl J, Kirkham M. *Women's perceptions of informed choice in maternity care. Midwifery 2002; 18(2): 136-144*

Objective: to describe the extent to which women using maternity services perceive that they have exercised informed choice. Findings: 54% of women perceived that they exercised informed choice overall in the antenatal sample (95% CI: 51-57%) and 54% overall in the postnatal sample (95% CI: 52-56%). Perceptions of informed choice differed by decision point, varying between 31% for fetal heart monitoring during labour and 73% for the screening test for Down's syndrome and spina bifida in the baby. There were differences by maternity unit, even when the characteristics of women attending these units were taken into account. Multiparous women, women from manual occupations and women with lower educational status were more likely to feel that they exercised informed choice during antenatal care. These sub-groups of women were also more likely to report a preference for not sharing decision-making with health professionals. Conclusions: a large minority of women felt that they had not exercised informed choice overall in their maternity care. The perception of informed choice differed by decision point, maternity unit and characteristics of the woman.

Midwifery

Ref ID 671 - Alexander J, Anderson T, Cunningham S. *An evaluation by focus group and survey of a course for Midwifery Ventouse Practitioners. Midwifery 2002; 18(2): 165-172.*

Objective: to evaluate the Midwifery Ventouse Practitioners' (MVPs) Course and the MVPs' perception of its effect on their practice. Findings: important issues were identified by the focus group and informed the development of the questionnaire which achieved a 100% response rate. The mean length of full-time experience as a midwife was 18.6 years (SD 6.8; range 9-33); 11 midwives were based in community maternity units and seven in consultant units. 17 of the MVPs had been called to assist 505 women in this capacity; 366 (72%) had an MVP ventouse-assisted birth, 129 (26%) a normal birth and 10 women (2%) needed obstetric assistance. In this regard, there were considerable differences between individual MVPs. The midwives gave high priority to woman-centred values and to the very judicious use of intervention. They felt that the course had increased their confidence in relation to their midwifery practice, in general, and their ability to define fetal position and station, in particular. They reported a high level of confidence when undertaking their first ventouse birth after completing the course. [Author]

POSTNATAL

Mental Health

Ref ID 667 - Shakespeare J. *Health visitor screening for PND using the EPDS: a process study. Community Practitioner 2002; 75(10): 381-384.*

Objectives: To study the efficiency of services delivered to women by health visitors within a local postnatal depression (PND) strategy by examining data about screening with the Edinburgh Postnatal Depression Scale (EPDS) at eight weeks and eight months, reasons why women were not screened and the number of women who received "listening visit". Results: