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Private Health Practitioners' Experience of and Attitude towards Screening for Postnatal Depression

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A minor dissertation submitted in partial fulfillment of the requirements for the award of the degree of Master of Arts in Clinical Psychology

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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## **ABSTRACT**

Ten to fifteen per cent of women from affluent countries, utilising private health care services are diagnosed with Postnatal Depression (PND) annually. Despite the high prevalence and the negative consequences for mother, child and partner, PND remains largely undiagnosed. Thus, this study explored health practitioners' experience of and attitude towards screening for postnatal depression to explore the barriers to screening as well as potential mechanisms to improve the rate of detection. Twelve semi-structured interviews were conducted with health practitioners including general practitioners, gynaecologists, paediatricians and clinic sisters. Interviews were analysed using thematic analysis. The results indicated a number of barriers to screening including time, lack of training, the mother not being the primary patient, poor access to tools, ethical issues as well as other medical issues taking precedence. In order to overcome these barriers and increase the likelihood of screening, practitioners recommended the development of a protocol for the management and referral of PND, the use of an efficient and effective screening instrument in their practices as well as training regarding the administration and scoring of such a instrument.

**Keywords:** health practitioner, missed opportunities, postnatal depression, screening

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## **CHAPTER 1: INTRODUCTION**

Postnatal depression (PND) is currently considered to be the most common health problem faced by new mothers (Kabir, Sheeder & Kelly, 2010). It affects approximately 10-15% of such mothers utilising private health care services in high income countries (Olson, Kemper, Kelleher, Hammond, Zuckerman & Dietrich, 2002; Perfetti, Clark & Fillmore, 2004; Sit & Wisner, 2009). The symptoms of PND are such that if undiagnosed and consequently untreated, they will have negative consequences for not only these women, but their families as well (Gausia, Fisher, Algin & Oosthuizen, 2007; LaRocco-Cockburn, Melville, Bell & Katon, 2003; 2004; Redshaw & Van den Akker, 2007).

PND largely shares the DSM-IV-TR criteria for Major Depressive Disorder (Perfetti et al., 2004); however, it distinguishes itself from this diagnosis in terms of its onset. A consensus agreement between researchers and clinicians suggests that the onset of PND does not necessarily have to occur within the first 4 weeks after the birth of the child but in fact can occur within the first year of childbirth (Perfetti et al., 2004). At least one study finds that in 25-50% of cases, depression can persist for more than 7 months (Sit & Wisner, 2009). These time periods are of consequence for those concerned with screening for PND.

In terms of the actual symptoms, mothers who develop PND meet the criteria for a Major Depressive Episode. Symptoms include a depressed mood, diminished interest in activities, feelings of worthlessness and guilt, detachment from the broader social world and loss of appetite (Basten, 2009; Perfetti et al., 2004). Depressive symptoms specifically associated with the experience of having had a child include detachment from the infant, guilt regarding poor parenting, and fear of hurting the child (Olson et al., 2002; Sit & Wisner, 2009).

As a result of these symptoms, mothers tend to have diminished capacity in terms of their ability to provide their child with the necessary care and attention required for normal development (Perfetti et al., 2004). Naturally, this will be to the child's detriment. Infants of mothers with PND experience greater delays in motor and cognitive development as well as affect regulation, in comparison to infants of unaffected mothers (Gausia et al., 2007; Perfetti et al., 2004). Indirectly, the child's health and nutrition may suffer as a result of the mother's inability to attend pre-planned appointments with the paediatrician or from the use of poor breast feeding techniques (Chaudron, Szilagyi, Campbell, Mounts & McInerny, 2007). Moreover, the impact on the child can be long lasting. Research has shown that young boys exposed to maternal depressive symptoms are likely to have cognitive deficits and develop

behavioural problems as they mature, while young girls are likely to experience future depressive symptoms themselves (Olson et al., 2002).

What is important to recognise is that there are a number of occasions at which the maternal symptoms may be detected in those mothers able to afford private healthcare services. During the postnatal period, there are a number of pre-planned appointments which the mother should attend. These include her 6-week gynaecological check-up, the child's first 6-week paediatric consultation and the 8-week appointment at the breast feeding clinic. Furthermore, there commonly is a 1 year check-up with the general practitioner for both mother and child. In between these scheduled consultations, if either one falls ill, additional appointments will be made to see the relevant practitioner. Important to note is that all these appointments fall within the potential PND onset period. It is clear that there exist a number of opportunities for detection of PND. These scheduled consultation slots thus appear to be the ideal place for the screening and diagnosis of PND.

Given the aforementioned consequences, the identification of women with PND or who are at risk of developing it, should thus be of considerable concern to those health practitioners responsible for the mother's wellbeing and that of their child, throughout and post pregnancy (LaRocco-Cockburn et al., 2003; Perfetti et al., 2004; Ramchandani, Richter, Stein & Norris, 2009). However, even with extensive research providing evidence for the above consequences and despite the number of opportunities available for screening, PND remains largely undiagnosed and as a result untreated (Gausia et al., 2007; Perfetti et al., 2004). This begs the question: why is this so?

International literature suggests that poor detection is as a result of a number of reasons. For the most part these reasons are associated with the patient's characteristics, the health practitioner's role and screening protocol and referral systems.

Mothers will not actively seek help if they are struggling to function effectively during the postnatal period (Dennis & Chung-Lee, 2006; Olson, Dietrich, Prazar & Hurley, 2006). This may be partly as a result of the stigma attached to the diagnosis of depression and the resulting shame mothers may experience due to their inability to cope and care for their child (Perfetti et al., 2004). Furthermore, during pre-planned appointments, the mother will attempt to lessen the presentation of her depressed symptoms. Here, the mindset of the mother is such that she associates her depressed mood with being an unfit parent and consequently will attempt to conceal her feelings from her practitioner for fear that her child will be placed with a more fit person (Perfetti et al., 2004). Under-reporting of symptoms also increases as a result of the influence of the mother and sisters of the new mother, who have

already experienced pregnancy and who describe the emotions associated with this experience as normal (Perfetti et al., 2004). All the above issues impact on the practitioner's ability to detect PND in their patients.

One of the major logistical factors associated with poor detection is the length of the patient's consultation in conjunction with the practitioner's assumption of the time it will take to screen for PND (Olson et al., 2006). Given the pressurised nature of their work, practitioners have a limited amount of time to diagnose and treat those symptoms which the patient has described or is overtly presenting (LaRocco-Cockburn et al., 2003). This may result in the use of informal screening techniques, i.e., the practitioners own judgement of the patient's wellbeing, as opposed to using a formal screening tool; or not screening at all (Perfetti et al., 2004). This may be problematic for a number of reasons. Here, the main reason being that the practitioner may not have the necessary and relevant knowledge required to correctly detect PND. The use of informal screening techniques may also be as a result of an under-resourced health care system which is not geared towards screening and consequently provides practitioners with insufficient training opportunities (Gausia et al., 2007).

A positive attitude towards screening, confidence in one's ability to successfully screen for PND, in addition to a high psychosocial concern are practitioner characteristics which are likely to increase screening for PND (LaRocco-Cockburn et al., 2003). Contrasting research has revealed that diagnosing PND does not necessarily result in improved outcomes for the mother and child. This fact has served to decrease the probability of practitioners screening for PND as they are concerned that knowledge of the diagnosis will cause more harm than good (Kabir et al., 2008). However, despite the above, if the right treatment is available, practitioners are more inclined to screen for PND.

It is important to note that these issues may to an extent differ across different health professionals (general practitioners, gynaecologists, paediatricians and clinic sisters from vaccination and/or breast feeding clinics) concerned with caring for the mother and child. This may be as a result of their attitude towards and previous experience of screening, their professional role requirement and their knowledge of PND. Given that limited research has been conducted in South Africa in relation to PND and the detection thereof, it is necessary to investigate whether in fact South Africa is faced with these same screening issues and how they can be dealt with.

Research has clearly shown that the onset of PND not only has negative consequences for the wellbeing of these women but also for the overall development of their child, their

marital relations and social contacts. However the literature has made it evident that despite the evidence of the prevalence and existing consequences and potential opportunities for screening, PND is largely undetected and as a result remains undiagnosed. Thus, the aim of the current study is to determine why this is so in the South African context in addition to garnering practitioner opinion on ways to improve detection. This was achieved through investigating the health practitioners' attitude toward and experience of screening for PND in the private health sector.

University of Cape Town

## **CHAPTER 2: LITERATURE REVIEW**

### **INTRODUCTION**

This chapter provides an outline of the current literature on PND and its low detection rate in relation to health practitioner's attitude towards and experience of screening for PND. Given the dearth of PND research in the South African context, the literature drawn on is largely from international sources. The chapter firstly seeks to define and frame PND and comment on the prevalence of this illness. This includes commentary on the risk factors associated with PND and its related consequences; not only for the mother, but for her child and partner as well. The next section describes the appointments at which formal PND screening may occur, highlighting the number of times the mother is in the presence of a health practitioner, whether it be for her own wellbeing or that of her child. The discussion then turns to screening of both general health and mental health conditions and more specifically PND. In this section reasons as to why practitioners may or may not screen for either condition are discussed so as determine whether a difference exists between screening for those conditions and PND. This is followed by discussion regarding specifically screening for PND. Here reference will be made to patient characteristics and health practitioner purpose as a result of their discipline. Finally, a protocol specifically designed to detect PND will be discussed.

### **DEFINING POSTNATAL DEPRESSION**

For many mothers, childbirth as well as the initial period of motherhood following this event is considered one of the most stressful times in their lives (Ussher, 2004). The baby's arrival is most commonly associated with excitement and elation of the parents and their extended family and friends (O'Hara, 1997). However, over time as the novelty wears off, the level of support dwindles and the reality of the responsibility of a new baby is realised, these initial feelings may turn to sadness, irritability and frustration. It is these feelings, which if they continue to persist and increase in severity to the point where the mother feels unable to cope with her baby, may develop into PND (Ussher, 2004).

PND is possibly best understood in terms of a continuum. This continuum is inclusive of three phenomena (Kendall-Tackett & Kantor, 1993). The phenomenon of "baby blues" exists on the lower end of the spectrum, while on the upper end of the spectrum is that of postpartum psychosis. PND is typically regarded as falling mid way between these two mood states. The former is considered mild and transient in nature, while the latter far more severe and volatile (O'Hara, 1997).

“Baby blues” is commonly experienced by 50 to 85% of mothers (Leitch, 2002). It is said to occur in the first few days after the mother has given birth, peaking on the fifth day, usually drawing to a close by the twelfth day (Leitch, 2002). Symptoms may include tearfulness, mood lability, physical exhaustion, insomnia and anxiety (Leitch, 2002; O’Hara, 1997; Ussher, 2004). These symptoms are reflective of the changes the mother is going through as she adjusts to life with a newborn. Doctors comment that this mood state is often as a result of the health procedures performed during childbirth as well as hormonal changes experienced by the mother (Ussher, 2004). If these symptoms continue to persist for more than two weeks, warning bells should signal those within the mother’s context, especially health practitioners, to question whether she has progressed into PND (Leitch, 2002).

In contrast to “baby blues”, postpartum psychosis is an extremely rare illness resulting in gross impairment of the mother’s functioning (O’Hara, 1997). It appears to be relatively infrequent, affecting fewer than two in 1000 births and commonly occurs within the first 3 weeks post birth (Jones & Venis, 2001). The symptoms experienced are more severe than those of baby blues and PND and include hallucinations, delusions, obsessive rumination about the baby, constant activity, suicidal ideation and thoughts regarding possible infanticide (Jones & Venis, 2001; O’Hara, 1997). The severity of this illness is evident in the need for treatment extending beyond medication to possible hospitalisation (Leitch, 2002).

It is important to note that according to the DSM-IV-TR (2000), neither baby blues nor postpartum psychosis are considered formal diagnostic categories. Instead they provide information regarding onset period and illness severity in relation to PND. The baby blues does not meet the criteria in terms of duration or severity, while postpartum psychosis is often diagnosed formally as a manic or depressive episode or even brief psychosis (O’Hara, 1997; Kendall-Tackett & Kantor, 1993). The above distinction should assist health practitioners in determining where along the continuum their patient might fall and enable them to manage her symptoms accordingly. The continuum thus creates a useful guideline for practitioners to informally assess whether their patient has in fact developed PND.

Prevalence statistics indicate that on average 10 to 15% of pregnant women in high income countries will develop PND (Leitch, 2002; Olson et al., 2002; Perfetti et al., 2004; Sit & Wisner, 2009). According to the DSM-IV-TR (2000) the onset of this depression may occur within the first four weeks postpartum up until the first year of the child’s birth. The onset tends to be gradual, with the symptoms persisting for months (Leitch, 2002).

Research has shown that the symptoms of PND are not distinctly different from those of major depression; including depressed mood, feeling worthless, loss of appetite, insomnia,

irritability and decreased libido (Ogrodniczuk & Piper, 2003). Symptoms more specific to this form of maternal depression include; the mother feeling unable to care for her infant, wanting to hurt her infant, difficulty in attachment, guilt associated with poor parenting and the inability to cope without her partner present (Olson et al., 2002; Sit & Wisner, 2009). In addition to these symptoms, where PND does appear to differ from major depression is that it occurs at a time where the demands placed on the mother are more burdensome than usual (Ogrodniczuk & Piper, 2003).

Frequently mothers are surprised by the conflicting feelings they have during this period of assumed happiness (Kendall-Tackett & Kantor, 1993). The transition into motherhood can be an overwhelming experience, given the multiple stressors which occur simultaneously (Ussher, 2004). Whilst attempting to recover from the physical and emotional experience of giving birth, the mother must also care for her infant as well as her family (possibly including her partner and/or child/ren). In addition to managing this balancing act, developing PND further compromises the mother's ability to function effectively. This negatively impacts on both her infant and her partner (Ogrodniczuk & Piper, 2003).

### **Consequences of PND**

The major consequences for infants are associated with their developmental outcomes, attachment styles and general health. Developmental outcomes for infants parented by mothers who suffer from PND tend to be negative. Research has shown that these infants are likely to experience difficulty in cognitive processing, delays in motor functioning as well as poor affect regulation (Gausia et al., 2007; Perfetti et al., 2004). Furthermore, longitudinal studies for children exposed to PND provide evidence that the effects of PND are long lasting. This can be seen in the different consequences experienced by these children as they mature. Girls are more likely to experience future depression, while boys are more likely to manifest a number of behavioural problems (Olson et al., 2002), such as hyperactivity and distractibility (Grieg, 1998). These difficulties may impact on educational productivity as well as the development of appropriate social skills, both of which will have an impact on any future accomplishments.

Furthermore, PND has been shown to have negative consequences for mother-child interaction. For the development of a secure attachment, during the early postpartum months, mothers need to be present, responsive and provide a secure base from which the infant can explore (Onozawa, Glover, Adams, Modi & Kumar, 2001). Given that both PND and attachment occur during this period, it is likely that the former will have a negative impact on

the latter. This is evidenced by research which has shown that infants of depressed mothers are more likely to display insecure attachments than infants of non-depressed mothers (Lindgren, 2001). Exposure to this attachment style may have consequences for the manner in which these infants will bond with their own children and partners.

In terms of the infant's general health, research has found that mothers suffering from PND often neglect to remember their infant's fixed health appointments (Chaudron et al., 2007). As a consequence of this, the infant may potentially be exposed to unnecessary illness if he/she has not been vaccinated accordingly or attended regular paediatric appointments. Furthermore mothers may struggle to breast feed properly. This not only negatively impacts on the infant's source of nutrition but also the mother's opportunity to influence the security of their attachment (Chaudron et al., 2007).

Lastly, the emotional state of the mother suffering with PND negatively affects her relationship with her partner (Soliday, McCluskey-Fawcett & O'Brien, 1999). This is evident in that maternal PND has been associated with increased paternal depression and higher paternal parenting stress which negatively impacts on partner-infant interaction (Goodman, 2008). The development of an uneasy, negative relational style may have further consequences for attachment with the infant and their overall development. Given the potential consequences for mother, child and partner, it is important that those practitioners in contact with the mother screen her for PND. Appropriate treatment can then be arranged.

### **Appointments with health practitioners**

The World Health Organisation (2010) recommends a number of fixed appointments for infants in their first year. Paediatric appointments are at 6 weeks, 6-9 months and 1 year of the child's birth along with vaccinations which generally take place at well-baby clinics at 6-8 weeks, 10-14 weeks, 14-20 weeks, 9 months and 1 year. According to Doctor Sinclair, a practicing paediatrician in Cape Town, who has a special interest in well-baby clinics, (personal communication, June 18, 2010) this schedule is also used in South Africa for mothers who are able to afford private healthcare.

Additionally, at six weeks, the mother has a gynaecological appointment for a post-birth check-up and to have any stitches removed. In addition to this she will later have her annual gynaecological appointment as with the general practitioner who should also see both mother and child at the one year mark. Over and above these fixed appointments, additional visits might occur if either mother or infant is unwell or if the mother is concerned about her infant's health.

Furthermore, mothers seeking advice from breastfeeding counsellors at a health clinic will generally meet with them on the first day after delivery as well four times during the first eight weeks post birth. Thereafter possible appointments might relate to growth monitoring and family planning. These appointments may also be attended to by the abovementioned health practitioners.

Not including all possible appointments highlighted above, in total there are ten fixed appointments throughout the first year of the child's birth: the PND onset period. These appointments are relatively well dispersed across the year. Both the number of appointments and their time slots should provide the relevant practitioners; be they gynaecologists, paediatricians, clinic sisters or general practitioners, with the ideal opportunity to detect symptoms and screen for PND, with the hope of preventing or treating this mental illness, given the mother's state post pregnancy.

### **Screening for PND**

There is a definite consensus among practitioners and academics alike, that PND is an important health care concern (Leitch, 2002). Yet this concern, despite the high prevalence rate, negative consequences as well as the number of appointments at which health practitioners are in contact with mother and infant, has not yet become the focus of much (if any) clinical attention, even in the relatively well-resourced private health care system that is the focus of this study. Here, attention is understood in terms of raising awareness, increasing formal screening and diagnosis of PND as well as developing formal referral systems and improving the treatment of cases (Ogrodniczuk & Piper, 2003).

The majority of PND cases remain undetected and consequently untreated (Gausia et al., 2007; Perfetti et al., 2004). This is largely as a result of patient characteristics, no profession motivated to screen for the PND, as well as the lack of formal screening protocols implemented in health practices. In order to create a picture of formal screening and the reasons relating to its poor implementation, research will first be examined in relation to screening of general health conditions.

### **SCREENING FOR GENERAL HEALTH CONDITIONS**

For the purpose of this section, two well known illnesses were selected; type 2 diabetes and breast cancer, as illustrative of screening for general health conditions as well as being chronic, silent disorders, much like PND. The discussion will make reference to the barriers to screening.

## **Type 2 Diabetes**

Once present, type 2 diabetes cannot be cured but only managed (World Health Organisation, 2010). Thus early detection and treatment thereof is beneficial in that it is likely to result in fewer health complications and consequently a healthier lifestyle for the patient (Whitford, Lamont & Crosland, 2003). Screening for this illness is thus clearly beneficial.

However, despite its severity and the argument for early detection thereof, there still appears to be a moderately high level of noncompliance with the screening protocol for type 2 diabetes (Moturr-Pilson, Snow & Bartlett, 2001). Common reasons for noncompliance include practitioner knowledge, conscious decision making, practitioner oversight, patient non-adherence and system related issues (Moturr-Pilson et al., 2001).

Physicians with a greater knowledge of screening for type 2 diabetes, including awareness of and training in the methods used to detect this condition, are more likely to screen patients than those who are limited in these areas. The likelihood of screening is further enhanced in cases where physicians experience a good level of self efficacy (belief in their ability to detect type 2 diabetes) and a high outcome expectancy (that the results of screening will be treated and managed appropriately) (Moturr-Pilson et al., 2001)

In instances where physicians do not comply with best practice regulations, they may consciously decide to disagree with them and act accordingly. This largely relates to cases in which other health matters were more pressing than screening for type 2 diabetes or cases in which the physician deemed screening unnecessary as a result of the patient's current health status. In contrast, physician oversight may also contribute towards noncompliance with screening guidelines (Moturr-Pilson et al., 2001).

Patient non-adherence relates to patients missing appointments or declining screening (Moturr-Pilson et al., 2001). The former reason prevents physicians from educating patients on the benefits of screening, while the latter may be indicative of patient preference and/or possible anxiety surrounding screening (Whitford et al., 2003). Patient non-adherence is also associated with system-related issues which relate to poor communication between patient and healthcare provider (Moturr-Pilson et al., 2001). Additionally Rhodes et al. (2006) found that limited time to provide counselling after screening was a significant barrier to screening.

Whitford et al. (2003) found that limited resources, including time and financing, acted as further obstacles to the detection of type 2 diabetes. The less financial stability within a practice, the less inclined health practitioners were to screen for this condition. This was supported by physicians who commented that resources were already limited given the

high number of diabetic patients being treated and as a result screening would only diminish these resources further (Whitford et al., 2003). Furthermore, screening patients in addition to carrying out the normal physical examination required additional time for which physicians were unlikely to be remunerated.

Despite the above barriers to screening, the diabetes literature offers a few recommendations to increase practitioner compliance with best practice guidelines for type 2 diabetes screening. Physicians should be involved in designing a system to improve compliance given that screening of this condition is dependent on their efforts (Moturr-Pilson et al., 2001). Furthermore, it was recommended that screening methods should be both practical and feasible as physicians are more likely to screen when there are low to no costs and the test itself is easy to administer (Rhodes et al., 2006). Lastly, healthcare providers and insurance companies need to be provided with the necessary material to educate their patients/customers about type 2 diabetes and the benefits of early detection which can be experienced as a result of screening.

### **Breast cancer**

As with type 2 diabetes, early detection is essential given the severity of the illness and that if treated upon detection is likely to result in a positive outcome for the patient (Smith & Haynes, 1991). Despite this reasoning, a large majority of women remain at risk due to not being screened at minimal intervals resulting in missed opportunities for early detection (Leitch, 1995; Smith & Haynes, 1991). Missed opportunities can be understood in terms of barriers to screening. These include the perceptions and practices of healthcare providers, limited resources as well as the patient's perception of screening (Leitch, 1995; Smith & Haynes, 1991)

In terms of the perceptions and practices of healthcare providers, one study (Smith & Haynes, 1991) reported that two thirds of the participating physicians would not order a mammogram if the patient was receiving episodic care while 26% would not recommend screening if they were not treating the patient for gynaecological reasons. The former result emphasises the importance health practitioners place on regular screening intervals while the latter highlights the value of professional skill. Further, both financial remuneration as well as detection expenditure were perceived as obstacles to screening in that almost half (41%) did not screen for breast cancer as a result of inadequate insurance with over a third (37%) not screening due to the high cost involved.

Practitioners were also concerned with false positives, the consequences of which may result in unnecessary surgery, heightened patient anxiety and avoidable health costs. In contrast however, was the possibility of finding a false negative which has the ability to lull both physician and patient into a false sense of security. This may have negative consequences for prognosis given the delay in treatment (Leitch, 1995).

Resource-related constraints relate to time limitations and work pressure. These two factors often result in poor screening compliance as a result of more pressing health concerns expressed by the patient, and the already limited duration of the appointment (Smith & Haynes, 1991). In addition, inadequate reminder-systems responsible for ensuring timely mammograms as well as physician oversight further hamper the screening process.

Women who have a personal or family history of breast cancer or other cancers and/or have experienced an abnormal mammogram are more likely to request screening from their health practitioner as would those who experience high levels of suspicion and anxiety regarding this illness. In contrast, many women have not been screened as a result of a lack of awareness that they in fact need to be screened for breast cancer or their doctor has not informed them thereof. Additional patient barriers to screening include the cost of a mammogram, limited insurance coverage for both screening and treatment in the case breast cancer is detected as well as health concerns regarding radiation (Smith & Haynes, 1991).

Despite the above barriers to detection, the literature offers a few suggestions to increase the detection rate. One study suggested that health practitioners should encourage all eligible patients to be screened for breast cancer given the weight of their advice and influential role. Furthermore, health practitioners should follow the screening guidelines for breast cancer as this will assist in consistent adherence to policy, reducing the number of missed opportunities (Smith & Haynes, 1991).

Smith and Haynes (1991) highlight the importance of practitioner knowledge regarding the practicalities of screening and its associated health benefits. This will allow them to confidently inform their patients about the process. This will reduce the anxiety they experience and consequently is likely to increase their desire to be screened. Lastly, to assist with early detection, practitioners should encourage their patients to self examine their breasts monthly (Smith & Haynes, 1991).

Both diabetes and cancer are serious, chronic health conditions, and as a result of there being no apparent symptoms present in the early stages, they are often harder to detect. This is similar to PND: given the stigma attached to this illness as well as those affected mothers wanting to present as a capable parents, PND symptoms are frequently masked. This

hinders the health practitioner's ability to detect any signs of depression. In both cases, for general health and mental health conditions, symptoms are often only detected through the use of formal screening techniques. Early detection of diabetes, cancer as well as PND has been supported by health practitioners given the severity of each condition and its associated consequences for the patient's quality of life as well as that of their families.

## **SCREENING FOR PND**

Although screening tools are available and effective treatment does exist, studies from the North American, British and European and Australian contexts find that routine, formal screening for PND remains infrequent, negatively affecting the detection rate of mothers developing this illness (Baker-Ericzen, Garnand Mueggenborg, Hartigan, Howard & Wilke, 2008). Barriers preventing mothers from seeking help, health practitioner's professional role as well as the protocol designed to detect PND, all contribute towards this infrequency. No similar studies in South Africa could be identified.

## **Mothers' help-seeking behaviours**

Worldwide, it appears that mothers have been suffering with PND for years without diagnosis and treatment (Dennis & Chung-Lee, 2006; Olson et al., 2006). The guilt they experience as a result of not feeling the joy and happiness which the majority associate with childbirth and motherhood assists in maintaining this silence (Leitch, 2002). Findings of a study investigating women's help-seeking behaviours during the postpartum period support the above, in that only 18 of the 38 participants sought help from professionals or family and friends (McIntosh, 1993). This study highlighted a number of the barriers preventing mothers seeking help and consequently being screened, stigma playing a major role.

The stigma attached to depression further contributes to this silence. The shame experienced by mothers as a result of their inability to care for their infant decreases their willingness to express their feelings to health practitioners, family and/or friends (Denis, Chung-Lee, 2006; Perfetti et al., 2004). In a study of 38 mothers, 16 reported regarding acknowledgement of their struggle as a sign of personal inadequacy and admission of failure as a mother (McIntosh, 1993). The above reluctance to communicate can be further understood in that new mothers often internalise an idealised image of motherhood and when in fact they cannot realise this image outwardly, they experience a sense of failure (Ussher, 2004).

There are some mothers who view motherhood as an aim in life, alongside their career and the achievement of financial independence. This mindset may result in mothers wanting to present themselves as successful in all facets of life, especially to other professionals, in this case health practitioners, who they believe may judge their parenting abilities (Ussher, 2004). Given a need to present as a competent parent, mothers will frequently conceal their depressive-like symptoms during health appointments (Perfetti et al., 2004)

Family members' reactions towards the mother's emotional state may vary from highly supportive to completely indifferent and possibly even aggressive (McIntosh, 1993). This may impact on a mother's willingness to disclose depressive symptoms. Underreporting of symptoms is further worsened in cases where mothers experience their families as unsupportive (McIntosh, 2003).

Female family members who have given birth prior to the new mother giving birth may comment that the feelings experienced during the postpartum period are normal (Perfetti et al., 2004). As a result, mothers feel isolated and unsure of their capabilities as parents and consequently are less inclined to ask for help or disclose their symptoms.

The disclosure of symptoms is further influenced by the mother's perception of depression. Given the stigma attached to depression and the need to appear as a competent parent, mothers frequently perceive their emotional state as stressed rather than depressed (Olson et al., 2006). This consequently delays progress towards meeting with a health practitioner for screening.

Furthermore, one study found that some mothers suffering from PND tend to associate the cause of their illness with external stresses relating to finances, housing and employment (McIntosh, 1993). They consider their problem of social origin as opposed to health origin. Here, their reluctance to access help stems from the belief that professional intervention would not contribute to the solution of their depression.

Those mothers who did in fact seek advice from health practitioners were prompted by the need for relief from symptoms which were having an excessively negative impact on their daily functioning. However, if the advice offered was not in accordance with the mother's understanding of her emotional status and its causes, it was rarely followed (McIntosh, 1993). In contrast, practitioner qualities such as being respectful of the mother's opinions, taking the time to listen, asking the right questions, anticipating her concerns and caring for her child, help the mother to develop a sense of trust. It is this trust which encourages mothers to communicate with their doctors (Heneghan, Mercer & DeLeone,

2010). Furthermore, mothers associate continuous, stable health relationships with having a competent health practitioner. This serves to increase the likelihood of compliance with advice offered (Heneghan, Silver, Bauman & Stein, 2000; Heneghan et al., 2010).

For the most part, it appears that mothers tend to guard their emotions rather closely. It is their reluctance to communicate their true feelings which hinders health practitioners' ability to detect PND (McIntosh, 1993). This is unfortunate given the potential for such practitioners to play a supportive role in their case. However, studies have shown that the role of health practitioners and their perceived responsibility in relation to PND is not without its complexities in terms of screening for this illness.

### **Health Practitioner Role**

Mothers utilising private health services are likely to be making appointments with gynaecologists, paediatricians, general practitioners and clinic sisters involved with breast feeding and/or vaccinations; be it for their own or their infant's wellbeing. This section will thus shift to focus specifically on the above practitioners and their perception of their role in screening for PND and how it impacts on the detection of this illness.

#### *Gynaecologists*

It appears that depression is commonly found in gynaecological settings, with 50% of women experiencing significant emotional disturbance during the postpartum period (Bennet et al., 2009; Yonkers & Chantilis, 1995). Routine screening has been shown to be an efficient and feasible method to improve detection of PND in such settings (Sit & Wisner, 2009).

Gynaecologists appear to be well positioned to screen for this illness given that they routinely examine mothers at 4 to 6 weeks postpartum, the date of this appointment falling within the onset period (Sit & Wisner, 2009).

The nature of the prenatal period and the number of examinations leading up to the delivery allows for the formation of a close bond between the patient and their gynaecologist (LaRocco-Cockburn et al., 2003). It is the nature of this relationship and the trust which the patient develops as a result which allows her to comfortably disclose information of a personal nature. This is supported by the findings of one study which has shown that women elect to seek treatment from gynaecologists over and above other physicians (Yonkers & Chantilis, 1995), providing further evidence that this discipline has a role to play in the identification of PND. Additionally, the fact that many women in the USA assume their gynaecologist as their primary health care provider should increase the likelihood that these

practitioners are likely to encounter PND in their practices (Bennet et al., 2009; Yonkers & Chantilis, 1995). Despite the plausibility of the above reasons as to why the detection of PND is in the scope of gynaecological practice, it is necessary to gain an understanding of the way in which screening is both perceived and practiced by this discipline and the implications of each.

One study investigating depression screening attitudes and practices among 282 obstetrician-gynaecologists provides a clear picture of their position in relation to screening for PND (LaRocco-Cockburn et al., 2003). Almost three quarters of the participants (73%) surveyed believed that depression was a common enough problem in women for them to screen for this illness in a systematic way. A further 65% believed that screening should in fact be conducted in their practices. When asked if they screened for PND, 44% of the participants responded often or always while only 15% responded never. Furthermore, attitudes towards screening were largely positive. The majority of the participants (99%) believed that screening would improve the rate of detection, with 79% believing that screening would result in early diagnosis and treatment (LaRocco-Cockburn et al., 2003). The above findings are significant in that they highlight practitioner awareness of PND and the recognition of their role in the identification of this illness.

The same study (LaRocco-Cockburn et al., 2003) found that the ease of screening was a major factor determining whether or not gynaecologists engaged in PND screening. The majority of the participants (73%) reported that time constraints and other demands would be likely to interfere with screening while just under half (47%) acknowledged that screening all patients for PND would take away from matters normally dealt with during the consultation.

The amount of psychosocial concern varied among the participating gynaecologists (LaRocco-Cockburn et al., 2003). Almost half (48%) feared that their patients would become more dependent on them if they opened up discussion relating to the mother's emotional state while 56% acknowledged that the consultation time did not in fact allow for discussion of this nature. In general however, participants believed that their patients desired their psychosocial concerns to be addressed.

In terms of professional factors such as residency training, policy guidelines of the professional board, practice of their employer and scientific research, beliefs varied as to which factors influenced screening behaviour. The most significant factor appeared to be professional board guidelines, with 57% conducting screening as a result, with scientific research providing a supportive influence to 69% of the participants (LaRocco-Cockburn et al., 2003).

The last factor investigated in this study was that of training (LaRocco-Cockburn et al., 2003). Under half (45%) of the participants felt that they had not received the necessary training to screen or treat PND. Training not only equips a practitioner to perform a task, in this case screening, but it also has the potential to develop a positive attitude towards the task as well as build practitioner confidence (LaRocco-Cockburn et al., 2003).

The above findings relating to attitude towards screening, psychosocial concern and ease of screening were all shown to influence the gynaecologists' screening practices. Those practitioners with a positive attitude towards screening, a high psychosocial concern and a high ease of screening were more likely to conduct screening than those who experienced the above factors in lower to neutral levels (LaRocco-Cockburn et al., 2003). Professional factors and training did not appear to play a significantly influencing role. It thus appears that practitioner attitude is a major predictor of their behaviour towards screening.

The most common manner of screening (used by 81% of participants) involved gynaecologists asking patients questions about their mood state developed from their own frame of reference regarding PND. This method was deemed largely unreliable given its potential to result in false positives or false negatives. Thirty-two percent used a short validated tool and 16% a validated patient self report test (LaRocco-Cockburn et al., 2003). The above breakdown of screening methods is supported by the findings of a study conducted by William et al. (1999) who found that obstetrician-gynaecologists were less likely to use formal criteria to diagnose depression in their patients than general practitioners.

Despite the limitations of the above study (its cross-sectional nature, the self-reported data, as well as the participants possible interest in depression), it draws attention to the fact that the issues relating to lack of screening and poor detection of PND are largely as a result of limitations (including time constraints, the lack of training and practitioners uncertain of whether diagnosis will result in improved patient outcome) as opposed to practitioner responsibility (LaRocco-Cockburn et al., 2003).

In a cross-sectional study of 226 women, investigating patient attitudes regarding help seeking intention in gynaecologic and obstetric settings (Bennet et al., 2009), contrasting results were found to in relation to the study conducted by LaRocco-Cockburn et al. (2003). The contrast is noted in terms of the acceptability of this setting for dealing with mental health issues.

This setting has not traditionally been associated with mental health care, despite the fact that depression is commonly associated with the postpartum period, a time in which women are likely to be examined by a gynaecologist (Bennet et al., 2009). Of the participants

who screened positive for depressive symptoms, only half reported they would seek help from their gynaecologist. This finding has implications for screening in this setting as it suggests patient resistance to care. The question here is whether this resistance is as a result of patient misperception of the gynaecologist's role and responsibility (which could be overcome through education) or whether it is as a result of an unresponsive, unqualified health discipline. The latter option is supported by research which shows that training in mental health matters received by 92% of obstetric-gynaecologists does not sufficiently equip them to manage cases involving mental illness such as PND. As a result only a minority of practitioners feel confident dealing with depression (Bennet et al., 2009).

It appears that gynaecologists are thus in need of additional training. Research has recommended focus be placed on assisting these practitioners identify mental illness within their practices (Schmidt, Greenberg, Holzman & Schulkin, 1997).

### *Paediatricians*

In the early postpartum period, paediatric appointments are concerned with infant development, vaccination schedules and assessment of their overall wellbeing. Nonetheless, the paediatric setting is also considered suitable for PND screening, given the timeline of appointments in relation to the onset of PND as well as the fact that the mother is typically present during these appointments (Connelly, Baker, Hazen & Mueggenborg, 2007; Mishina & Takayama, 2009). Ultimately however, the child is the paediatrician's primary patient. Contact with the mother during both fixed and unscheduled appointments provides the paediatrician with the opportunity to improve the child's outcomes through assessing their mother's emotional wellbeing and making referrals where necessary (Heneghan, Mercer & DeLeone, 2004; Olson et al., 2006). Furthermore, paediatricians are frequently the only health practitioners with which mothers may have contact after having given birth (Heneghan et al., 2004). The above highlights the fact that paediatricians have both a responsibility and a unique opportunity to contribute to the screening and identification of PND.

Despite this opportunity, screening practices used in paediatric settings appear to be inadequate as they are unable to detect the majority of mothers potentially suffering from this illness (Heneghan, Silver, Bauman & Stein, 2000). This inadequacy is as a result of the informal methods of screening being used. According to a study conducted by Heneghan et al. (2000) paediatricians reported using observation of symptoms and selective inquiry regarding the mother's wellbeing to identify PND. The former method is problematic given that mothers have been known to downplay symptom presentation for fear of practitioner

judgement (Perfetti et al., 2004), while the latter method highlights inconsistency of approach resulting in low detection rates. Ultimately both methods only detect the most severe cases (Connelly et al., 2007).

A similar study investigating paediatricians' recognition of PND found assessment of the mother's behaviour, appearance and complaints to be the most popular method of identification. PND was also suspected because of problematic family dynamics as well as its association with the child's presenting problem. Within using these methods, only a small sample of the participants reported actually asking the mother how she felt (12%) with even fewer using a formal screening tool (3%); again resulting in poor identification rates (Connelly et al., 2007).

In contrast, formal screening has been reported to add value in that it provides paediatricians with a feasible method to detect PND in their practices (Heneghan et al., 2000). Findings from one study have shown that screening for PND has been successful within the paediatric setting, especially when incorporated into their routine check-up (Connelly et al., 2007). Paediatricians who do in fact engage in formal screening (using a validated screening instrument) are more inclined to help those mothers who screen positive for PND (Heneghan et al., 2000).

Paediatricians have acknowledged that they are well positioned to screen for PND and consequently have a responsibility to identify this illness; however there are a number of perceived barriers which prevent both tasks from being achieved (Olson et al., 2002). A study conducted by Heneghan et al. (2004) which sought to investigate the PND recognition and treatment practices of 98 paediatric health care professionals explained that these barriers can be understood on an organisational, maternal and practitioner level.

The most commonly identified organisational barriers included 80.8% of the participating paediatricians feeling that the time to provide counselling or educate the mothers about PND was inadequate; following which 78.1% felt the appointment time was too short to take a satisfactory history. Other less significant barriers included the mother's insurance limiting treatment options (42%) and the expense of mental health professionals (35.2%). Surprisingly, barriers such as poor reimbursement for treatment (20.6%) as well as practitioner financial disincentives for mental health referrals (23.2%) had the least impact on attitude towards screening (Heneghan et al., 2004). The results from a comparable study conducted by Olson et al. (2002) echoed similar findings to the above with time relating to counselling/education (73%) and history-taking (70%) ranking as the most common barriers.

Maternal barriers largely appeared to relate to the stigma attached to PND and the sensitive nature of broaching this topic with 34.7% of mothers reluctant to see a mental health professional and 29.2% unwilling to accept this diagnosis. The most common barrier however related to the health problems of the child taking precedence over the mother's emotional state (43.1%) (Heneghan et al., 2004). Again, in relation to the research of Olson et al. (2002) the findings were similar if somewhat lower in certain instances.

On the practitioner level, over half of the paediatricians (53.4%) felt that incomplete diagnostic/counselling-skills training were the most common barrier to screening. Both incomplete knowledge of treatment for depression (34.7%) and limited knowledge of the DSM-IV-TR diagnostic criteria (34.7%) held equal influence (Heneghan et al., 2004). Olson et al. (2002) however found that the above practitioner related barriers were slightly higher in their study. Additionally, screening for PND raises a number of ethical and legal considerations for paediatricians regarding the boundaries of patient care and practitioner liability (Chaudron et al., 2007). If the paediatrician diagnoses PND and with due diligence refers the mother to the appropriate source, what if the mother does not accept this help and consequently harms her child? It is the responsibility brought on by this diagnosis which creates resistance to screening.

The findings from Heneghan et al. (2004) as well as Olson et al. (2002) suggest that paediatricians are not in fact engaged in the identification of PND. Overall, it appears that the above barriers as well as paediatricians' attitude towards and skills relating to screening for PND limit their ability to diagnose and manage this illness effectively. The literature however, makes reference to a number of recommendations to improve screening in the paediatric setting.

The findings of one study suggest that paediatricians should have access to brief screening tools given the success of two and three-question screening instruments which have been shown to produce superior test performance in paediatric practices (Mishina & Takayama, 2009). Over and above providing paediatricians with the appropriate screening instruments, it is necessary to train them in the administration and scoring of such tools. This will assist in boosting their confidence, allowing them to feel skilled in the identification of PND. It is hoped that as they experience an increase in screening competence, the aforementioned barriers will decrease (Connelly et al., 2007). This should help to alter their perception of formal screening, realising that it seeks to assist practitioners identify PND in an efficient manner.

Furthermore, paediatricians should seek to screen at regular intervals given the onset period of PND occurring anywhere from four weeks postpartum up until one year of the child's birth. If PND is in fact identified, it is recommended that these practitioners should assist the mother in question with an appropriate referral route (Mishina & Takayama, 2009) given that PND treatment is not in their field of expertise, nor is the mother their primary patient (Olson, et al., 2006).

However, findings of another study reported that paediatricians experience a lack of mental health resources (e.g. support groups, counsellors dealing specifically with PND as well as informative pamphlets) for mothers suffering from PND and as a result felt diagnosis would be meaningless. This study made the recommendation that paediatricians refer these mothers to the appropriate practitioners for treatment (usually including their physician or a psychologist) (Heneghan et al., 2000).

Further recommendation was made in terms of the screening style used by paediatricians. Given that those mothers suffering from PND largely feel they have failed as parents, paediatricians should attempt to appear supportive and non-judgemental as well as show empathy in their interactions (Heneghan et al., 2000). This should help paediatricians in their identification of PND as mothers should feel safe and consequently more accepting of the screening process. This feeling of safety and consequent disclosure was furthered by the continuous nature of the relationship between paediatrician and mother (Heneghan et al., 2004). Furthermore discussion regarding PND is made less difficult if framed in terms of the relevance of this illness to the infant (Connelly et al., 2007). Ultimately, the identification of PND and subsequent referral of the mother to the appropriate source will indirectly help the paediatrician care for their patient's wellbeing (Olson et al., 2006). The above recommendations are especially useful in cases where paediatricians in fact do not believe it is their responsibility to screen for PND.

Olson et al. (2002) suggest that the role of the paediatrician can be seen as two-fold. The first part involving the identification of mothers who they suspect to be suffering from PND, assessing the severity of their depression and deciding on the necessary course of action to take. The second part involves educating the mother regarding PND, providing support and offering practical advice regarding parenting and stress reduction. However, given that the paediatrician is not the mother's primary physician, they should only seek to offer guidance regarding possible further evaluation and/or treatment.

### *Paediatric nurses/Clinic sisters*

In comparison to the paediatric and gynaecological fields of practice, there appears to be minimal research examining nurse assessment of psychosocial problems in paediatric settings. That research which does exist, discusses the position of nurses in relation to other health practitioners as well as the qualities they bring to in a paediatric setting (Minde, Tidmarsh & Hughes, 2001). Both of these factors will assist in illustrating that nurses too are in a good position to screen for PND.

As with paediatricians, paediatric nurses are ideally situated to identify mothers suffering from PND. This is as a result of the extent of the interaction between nurse and mother during the first two years of the infant's life in which there are a number of fixed paediatric appointments to attend as well as a vaccination schedule to adhere to (Connelly et al., 2007). These encounters are typically with a nurse, rather than a paediatrician or other health doctor. Furthermore, the frequency and consistency of interaction results in the development of a trusting relationship between mother and nurse. Consequently, this relationship not only allows nurses to discuss the mother's emotional wellbeing (and so possibly to identify PND), but also actively to promote the wellbeing of the infant, who ultimately is their primary patient (Connelly et al., 2007). Screening for PND in the paediatric field should thus be promoted as it is congruent with the goals of paediatric care.

One study found that patients experienced nurses to be less threatening than doctors (Minde et al., 2001). Patients' experience of nurses as more approachable than doctors may be key in their ability to get reliable, valid information about the mother's mental health status (Minde et al., 2001). This consequently has implications for screening and the identification of PND.

The position in which nurses find themselves provides them with the opportunity to access sensitive psychosocial information which other health practitioners, given that some patients reportedly find them intimidating, may not otherwise have had access to (Minde et al., 2001). It is the nurturing role that nurses play in the health system which results in this less threatening experience mentioned above. Furthermore, mothers are also likely to feel more comfortable opening up to nurses as they perceive them to be on a relatively equal footing to themselves in contrast to doctors who they believe will judge the quality of their parenting (Ussher, 2004). The benefits of this position are further enhanced by the manner in which the nursing profession approached the assessment of mothers.

One study exploring nurses' and physicians' assessment of mother-infant mental health at the first postnatal check-up found that nurses spent twice as long with mothers and

their infants during their consultation slots than did physicians (Minde et al., 2001). This extra time allowed not only for the routine physical examination but also discussion regarding the mother's emotional wellbeing as well as any psychosocial concerns she may have had. All of the above was supported by the observation that mothers found consultations of this nature to be highly satisfactory and as a result were more willing to share personal information about their postnatal experience. This provided nurses with the opportunity to probe for any maternal mental health concerns, increasing the likelihood of detecting any possible cases of PND.

In the same study (Minde et al., 2001) nurses showed great concern for psychosocial functioning. This was seen in that a large part of their consultation focused on psychiatric and psychosocial maternal risk factors. Their concerns also related to accessing a global picture of the mother's wellbeing and ability to cope during the postnatal period (including examining factors such as birth complications, socioeconomic status, age and psychosocial problems). Furthermore, nurses would tailor their questioning according to the age and the extent of the mother's psychological difficulties, asking additional questions to younger mothers as well as those experiencing greater difficulties. The above approach allowed nurses to make a relatively accurate assessment of the mother's mental health.

The outcome of this assessment was enhanced by the sensitive interviewing style adopted by nurses. A caring and empathetic response served to encourage mother's expression of concealed thoughts and feelings (Minde et al., 2001). Furthermore, a study by Gallop, Lancee and Garfinkel (1990) found nurse-patient interactions to be supportive in nature. The above sensitivity along with a strong rapport, developed as a result of the frequency of interaction between nurse and mother, assisted nurses in openly discussing PND with the mother in question (Connelly et al., 2007). Thus the manner and style in which nurses approached the consultation with mother and infant can be seen as important to gaining the mother's trust and consequently accessing information relevant to PND. Despite the fact that nurses appear well situated to detect PND, there are a number of barriers which prevent screening thereof.

In the study examining paediatric health care providers' self-reported practices in recognising and treating maternal depression (Connelly et al., 2007), referred to in the paediatric section above, reference is also made to PND screening methods, referrals and screening barriers in relation to nurses.

The most popular screening method used by nurses was assessment of the mother's behaviour, appearance and complaints (92.6%) while almost half of the participants (42.9%)

relied on mothers introducing the topic of PND directly. Over a third (35.7%) suspected depression because of family dynamics as well as used the child's presenting problem as a guide for detection of depression (Connelly et al., 2007). Given the value associated with using formal screening, it was concerning to note that only 5.3% of participants used a screening instrument with none using formal diagnostic criteria.

The choice of screening method partly related to the nurses' level of confidence in their ability to recognise PND. Almost half of the participants (44.4%) felt they were capable of recognising maternal depression. Over two thirds of the nurses (76.9%) who did detect PND referred the mother to a mental health professional, while 30.8% counselled the mother for less than five minutes. Under a third of the participants (30.8%) stated that they would involve family members. It is encouraging to note that the majority of the participants engaged in some form of referral or management of the mother with only 7.7% not involving themselves in the case (Connelly et al., 2007).

The major barriers experienced by nurses in relation to the identification of PND were largely similar to those faced by paediatricians. The impact of some barriers did however differ. Again, these barriers can be divided along organisational, maternal and practitioner lines (Connelly et al., 2007).

On an organisational level, the majority of participants (78.6%) found inadequate time to provide counselling/education as well as the consultation time being too short to take an adequate history, the most common barriers to screening for PND. Additionally, barriers including the mother's insurance limiting treatment options (75%), unavailability of mental health resources (69.1%), mental health professionals not being affordable (64.3%) and difficult paperwork/authorisation procedures (53.8%) had more of an impact on nurses screening for PND than it did on paediatricians (Connelly et al., 2007).

On a maternal level, the health problems of the child being more pressing was identified as the most common barrier (64.3%). Equally limiting was the mother's reluctance to see a mental health professional (57.1%) with exactly half of the participants stating that her reluctance to accept a diagnosis would negatively impact on screening for PND (Connelly et al., 2007).

In terms of the practitioner, 42.9% of the participants indicated that incomplete diagnostic/counselling training served as a significant barrier. Incomplete knowledge of DSM-IV diagnostic criteria for depression (35.7%) also served to limit their detection ability.

Despite these barriers, it was encouraging to note that over two thirds (77.8%) of the participants indicated they planned to change and improve their PND screening and

identification strategies in the next six months. Almost all participants (94.1%) stated that they would inquire more frequently about PND with 41.2% changing to use a depression screening tool in their practice (Connelly et al., 2007).

A few suggestions have been made in relation to enquiring about the mother's wellbeing during their child's appointment, however few with direct reference to screening for PND. Kendall-Tackett and Kantor (1993) suggest that it is important for nurses to read between the lines, given that mothers may be wary to disclose personal information or discuss feeling depressed as a result of the stigma attached to depression. Additionally they recommend that nurses should seek to use direct questioning as opposed to general questioning. This type of questioning is more effective in that it will allow for greater access to the necessary psychosocial information. These suggestions largely relate to the interviewing style adopted by nurses during consultations with mother and child.

However, over and above interviewing style, Kendall-Tackett and Kantor (1993) also highlight the need to use a formalised, questionnaire or scale such as the EPDS (Edinburgh Postnatal Depression Scale) containing ten items specifically designed to assess the extent of PND in the mother. The EPDS has been validated for use in South Africa and is considered the most robust way of screening for PND (Lawrie, Hofmeyr, Jager & Berk, 1998). A validated scale of this nature will provide nurses with a reliable measure on which to base their decision for further evaluation, treatment or referral. Simply interviewing the mother and observing her behaviour may not yield sufficient information or be as valid as that of a validated questionnaire.

### *General practitioners*

As with the nursing profession, there is less research examining the role of general practitioners in the field of postnatal care than there is for gynaecology and paediatrics. Nonetheless, research has shown that depression has to an extent been both managed and treated in general practice in both Australia as well as the United Kingdom (Buist et al., 2005; Paykel & Priest, 1992). The findings of one Australian study (Gunn, Lumley & Young, 1998) however, highlighted that general practitioners do not in fact take advantage of their position to screen for PND. This was evident in that 12% of the participants did not routinely enquire about the mother's emotional wellbeing, 41% did not discuss her ability to cope with the child, 25% enquired about sleeping patterns while over half did not ask about time away from mothering or sexual relations with her partner. This is concerning given that these are all indicators commonly associated with the detection of PND.

In contrast, one British study found that many patients suffering from depression were in fact identified by general practitioners, but that still over half remain undetected. Further results indicated that 10% of the former patients were identified at later consultations, while 20% remain undiagnosed (Paykel & Priest, 1992). These findings are possibly indicative of poor to no screening used during the consultation.

This assumption is supported by research conducted in Australia which found that 50% of patients suffering from depression will be missed if some form of screening is not incorporated into the consultation (Buist et al., 2005). In the same study (Buist et al., 2005) it was shown that general practitioners will examine approximately 90% of women during the postpartum period. This highlights a major opportunity for these doctors to screen for PND, with early identification increasing the likelihood of improved outcomes for the patient.

From the above discussion it appears that general practitioners are to an extent identifying cases of depression and as a result must be in a relatively good position to screen for PND. Despite this, it is necessary to explore the various identification methods, referrals and barriers to screening so as to help explain how cases remain undiagnosed.

One study investigating 621 primary care physicians' approach to depressive disorders (Williams et al., 1999) found that the majority of family physicians (91%) screened for PND according to patient characteristics. It was encouraging to note that 41% of the participating physicians used formal criteria to diagnose PND, however at the same time, concerning that only 8% routinely enquired about depression in their practices.

An American study assessing whether family physicians were appropriately screening for PND (Seehusen, Baldwin, Runkle & Clark, 2005) found that general depression screening tools were a popular method for detecting this illness, with the structured clinical interview being utilised by the majority of participating physicians. It is evident from the above two studies that general practitioners rely on a combination of methods to detect PND including the use of both subjective and objective methods, allowing each to compensate for the other.

Seehusen et al. (2005) also explored physician beliefs regarding screening of mothers at postpartum checkups. It was encouraging to note that only 19.2% of physicians believed that screening at every check-up would take too much effort, with only 3.4% believing that screening at each appointment would not be effective. The former finding is promising in terms of the likelihood of practitioners actually screening for PND while the latter finding may result in an improved detection rate due to screening at multiple points during the postpartum period in which mothers may develop PND.

Patients positively associated the continuity with their general practitioner with a trusting relationship, further encouraging personal information sharing (Seehusen et al., 2005). Frequency of appointment also allowed for greater exposure, providing the general practitioner with the opportunity to observe emotional change in their patient, possibly detecting PND.

Cases in which PND was identified were either managed by the general practitioner themselves or referred on to the appropriate source, usually a psychiatrist. A referral was usually made if the general practitioner felt unequipped to deal with the severity of the psychological distress experienced by their patient or the patient doubted their advice (Paykel & Priest, 1992)

One of the major issues inhibiting screening in general practice relates to the fact that the appointment is predominantly associated with physical assessment as opposed to emotional assessment (Paykel & Priest, 1992). This focus hinders practitioner exploration of the patient's emotional symptoms.

In the study conducted by Seehusen et al. (2005), the majority of participants agreed that they should screen for this illness as the effects of this illness warrant its detection. This finding highlights the fact that apathy regarding PND and confidence in their ability to screen for it do not act as barriers to screening. However, despite practitioner awareness of the need to detect PND, access to formal screening instruments as well as research emphasising the need to administer such instruments, engagement in screening remains limited (Seehusen et al., 2005). Thus it becomes necessary to address the barriers hindering the identification of PND.

One of the major barriers faced by general practitioners is that of time (Seehusen et al., 2005). General practitioners are required to work according to a tight schedule given the number of appointments they are likely to have booked on a normal day. As a result they are under a great deal of pressure. Anything over and above the routine physical examination they are required to perform is seen as a burden. It is the connotations associated with this burden which influences practitioner perception of screening. Screening for PND, being considered as a mental health problem, thus does not take priority.

If in fact time was not considered a barrier to screening and the length of consultation slots were increased for this purpose, remuneration would consequently become an obstacle. General practitioners expect to be financially compensated for their services and consequently are not willing to extend appointments without additional remuneration, again impacting on the emphasis they place on screening (Paykel & Priest, 1992)

In addition to the above practical barriers, another obstacle influencing screening is the responsibility which is associated with making the diagnosis. Often general practitioners feel unequipped to manage a patient with PND (Paykel & Priest, 1992). This may be as a result of inadequate referral resources, incomplete knowledge regarding depression or poor to no training on screening instruments (Richards, Ryan, McCabe, Groom & Hickie, 2004). Thus practitioners would prefer to avoid diagnosis in the case they were unable to assist the patient directly or through a referral.

Another study showed that a lack of training associated with diagnosis and treatment of PND was a further obstacle to screening. This related to the fact that practitioners associated participation in training with confidence in diagnostic ability (Richards et al., 2004). Practitioners who felt unprepared to identify and treat PND were less likely to screen for it. However, despite the abovementioned barriers, the literature has made reference to a number of recommendations to improve the rate of PND detection.

One study highlighted the need to change the style of examination, with general practitioners shifting from routine physical examinations to indicated examination so as to allow more time for discussion regarding common postpartum problems faced by mothers (Gunn et al., 1998). If practitioners took a more careful physical history and limited the number of unnecessary examinations performed, more time could be spent on discussing issues of a psychological nature.

In line with the above, it has been recommended that the length of consultation slots be increased as they have been shown to result in improved detection rates (Paykel & Priest, 1992). Longer consultations allow general practitioners the necessary time to conduct the routine physical examination as well as engage patients on their emotional wellbeing post the birth of their child.

It is the style in which practitioners conduct these consultations which has further impact on the identification of PND. Those practitioners who exhibit the following qualities- empathy, recognition of non-verbal cues associated with depression, use of the patient's language to understand their position as well as tolerating verbal silences in order to allow the patient the space to express themselves- all contribute towards encouraging the patient to openly discuss topics of a sensitive nature. Furthermore, given the stigma attached to depression, it was advised that general practitioners educate their patients regarding PND (Paykel & Priest, 1992). It is hoped that this may have a positive effect on patient disclosure and acceptance of screening.

Just as formal screening is used for general health conditions such as diabetes or cholesterol, Paykel and Priest (1992) recommend that in order to increase the number of cases of PND detected, a formal interview including questions relating to specific symptoms of this illness be conducted during the consultation. Additionally, by providing practitioners with efficient and effective means of screening patients for PND, the detection rate should further improve (Seehusen et al., 2005).

In terms of education and training, one study assessing whether family physicians appropriately screen for PND recommended that the topic of PND be incorporated into the curriculum of students studying medicine (Seehusen et al., 2005). It was suggested that the curriculum include general PND information and training associated with the administration and scoring of formal screening instruments measuring this illness. Another study recommended that any training offered should be in a brief format given the pressurised nature of general practice (Kutcher, Lauria-Horner, MacLaren, Bujas-Bobanovic & Karlovic, 2003). However, for the knowledge to be utilised and screening to be put into practice, it would be essential to ensure that general practitioners are not only aware of the benefits of screening their patients for depression but also associate screening with minimal effort (Seehusen et al., 2005). Both factors would hopefully assist in practitioner screening compliance, ultimately increasing the rate of PND detection

#### *Practitioner summary*

It is apparent from the above discussion that the four practitioners share a number of similarities in terms of their screening methodology (such as behavioural observations, clinical interviews and the mother offering personal information) and the obstacles they face in identifying PND (insufficient training and lack of familiarity with screening instruments was common across all health practitioners as well as insufficient remuneration for extra time required to screen while lack of time was a problem for all except nurses).

Each practitioner given their profession has a set of skills which in parts differs from the others. It is this difference which may possibly allow for a collaboration of efforts as opposed to working in isolation with the mother, consequently increasing the likelihood of achieving a more positive outcome. Additionally, the appointments the mother and her infant have scheduled with each practitioner could allow for screening at multiple points during the onset period of PND as opposed to a single assessment by one practitioner. This may possibly allow for earlier detection of those suffering from this illness, again positively impacting on

their wellbeing. However, in order to achieve this collaboration and sharing of responsibility some form of protocol and referral system would need to be developed.

### **Screening protocol and referral systems**

One study found that a protocol specifically designed to detect and manage PND cases combated the barriers as discussed above. The model of the Partnership for Smoke-Free Families (PSF) Program was adapted into the Partnership for Women's Health (PWH) Program, with emphasis being placed on detecting and treating PND (Baker-Ericzen, Mueggenborg, Hartigan, Howard & Wilke, 2008). The PSF set out to connect health care providers to one another so as to allow productive interactions between themselves and the patient, and depending on the health status of the patient link them to the necessary services in a timely fashion.

The PWH program consisted of four stages. Firstly, mothers were assessed for PND using a standardised screening tool at postpartum visits (at the six and two month gynaecological visit). A copy of the test was placed in their file and the mother would receive educational material regarding PND. Secondly, mothers were advised depending on the review of their mental health. If their test score was indicative of PND, the severity of the case would be assessed and the appropriate referral made. Thirdly mothers were assisted in terms of their insurance options and emphasis was placed on normalising the depression. General support was provided by the health practitioner as well as the possibility of medication or therapy. Lastly, a follow up appointment was arranged for three weeks later so as to assess progress (Baker-Ericzen et al., 2008).

The benefits of this program can be seen from both the perspective of health practitioners as well as mothers. Health practitioners found the program to be feasible, easy to implement in their practices and reported that it increased their ability to detect and manage PND. This was evident in the results in that of the women identified with PND (16 out of 116), 94% received the necessary mental health care (Baker-Ericzen et al., 2008)

Women reported that they were comfortable with the process and liked the proactive contact between health practitioner and patient. Furthermore, they responded positively to discussing their mood with the practitioner assessing them. Overall, they believed the process assisted them in seeking help (Baker-Ericzen et al., 2008).

The success of the PWH program is also as a result of the composition of the advisory team, including paediatricians, psychologists, obstetricians, researchers and program managers. Their collaborative effort allowed for the incorporation of various professional

opinions. This resulted in the development of a program which was both feasible and effective in ensuring mothers with PND received the necessary care.

### **Conclusion**

It is clearly evident that there are multiple perspectives regarding screening for PND. Across the health professions reviewed, there exist both difference and commonality in terms of the barriers to screening for this illness. The most common barriers included limited time and work pressure, remuneration and the lack of training while the differences related to qualification, professional responsibility and health legal liability. These perspectives and their consequential screening barriers result in a complex interplay of factors impacting on the detection of PND and often resulting in missed opportunities to screen. There is thus a need for an exploratory study to help inform the development of a protocol and referral system specifically responsible for the identification and management of PND, specifically in the South African context. A system such as this has important implications for health practitioners in terms of the impact this assessment could have on mothers' emotional wellbeing, marital happiness and infant development. Furthermore, the development of a formal protocol may raise PND awareness which consequently may influence the number of mothers willing to acknowledge their need for treatment post pregnancy. Ultimately, there may be an increase in the number of mothers whose PND is detected and treated.

## CHAPTER 3: METHODOLOGY

### Design

Exploratory research designs are used to provide some understanding of the phenomena to be studied, for which generally there exists limited to no knowledge. Given that the researcher wanted to explore why PND remains largely undetected in the South African context, with the purpose of determining specifically what issues exist within the private health care system in South Africa as well as discover whether they differ from other contexts, it was decided that an exploratory design would be best suited for this purpose.

Currently in South Africa no research has attempted to understand why PND remains largely undetected. A number of international studies however have sought to determine the manner in which health practitioners detect PND as well as assess their experience of screening for and treating this illness (LaRocco-Cockburn et al., 2003; Sit & Wisner, 2009; Dietrich et al., 2003). The findings of these studies served as a valuable reference point from which to explore the issues relevant to the South African healthcare.

Thus through interviewing health practitioners who are concerned with the wellbeing of mother and/or child during the perinatal and postnatal period, this study sought to access the experiences and attitudes of health practitioners with regard to screening for PND. Furthermore, given that it was expected that there would be a number of missed opportunities to detect this illness, health practitioner opinion was sought regarding the development of a formal PND screening protocol and referral system.

Consequently a qualitative design using semi-structured interviews was deemed appropriate for this study. This type of design was considered most suited as it enabled the researcher to gain access to the participants' opinions (Hayes, 2000). The individual interviews conducted allowed for the collection of rich and in-depth data regarding the issues which exist in relation to screening for PND in South Africa. This allowed the researcher to discern nuances in practitioner opinion, such as those resulting from differences across discipline, personal experience and the manner in which they manage their practices (Babbie & Mouton, 2006).

## **Sample**

### *Characteristics*

Three health practitioners from each of the relevant professions (gynaecologists, general practitioners, paediatricians and clinic sisters) were selected to participate in this study. The gynaecologists included a white female and two white males, while the general practitioners include three white females. The paediatricians included a white female, an Indian female and a white male; and the clinic sisters included three white females. They were located within the greater Cape Town and surrounds.

All participants worked in private practice. This characteristic was determined by the need for consistency. Interviewing health practitioners from the public health care system would confound the results given the difference in working conditions and resources. This difference was likely to reflect a different set of barriers as well as recommendations to improve screening. Each participant had 2 or more years of experience in this field of care. This ensured sufficient exposure to mothers who may potentially have had PND.

### *Recruitment*

Participants were recruited using purposive sampling given that this study was concerned with conducting research with a specific group of individuals, namely health practitioners (Trochim, 2006). Initial contact was made with a general practitioner from a private practice in Stellenbosch as well as a psychiatrist from Groote Schuur Hospital. These practitioners are considered knowledgeable in the field of PND. The former practitioner has a special interest in working with mothers during the postnatal period and has done so for many years, while the latter practitioner sits on the Postnatal Depression Support Association (PNDSA) Board. Both practitioners provided referrals to participants.

## **Data Collection**

Semi-structured interviews were conducted with the participants. This type of interview was chosen as it combined elements of a structured interview (including the existence of an interview schedule, fixed roles of interviewer and interviewee and a relatively fixed time period) as well as the unstructured interview (emphasis on the participants experience and the use of open-ended questions) (Willig, 2001).

It allowed the researcher to capture essential data required to answer the research question while providing enough flexibility so that participants could contribute additional

information to the process (Babbie & Mouton, 2006). Thus it was anticipated that the interviews would provide the researcher with a solid, in-depth overview of the main factors contributing to the health practitioners' attitude and experience of screening for PND (Hayes, 2000). Furthermore, semi-structured interviewing was selected as the method of data collection given that it can be analysed using a variety of different techniques, allowing the researcher to select that which is best suited to answering the research question (Willig, 2001).

### **Materials**

The interview schedule (see appendix A) was adapted from a questionnaire developed by a team led by Jennifer Mertens (2008) of the Department of Research, Kaiser Permanente which explored practitioners' views of screening for substance misuse and HIV risk behaviours. In conjunction with themes arising from the literature (including current depression screening practices, attitudes regarding screening, psychosocial concern and professional influences) (LaRocco-Cockburn et al., 2003), the interview schedule was refined through conducting preliminary discussions with the health practitioners assisting with recruitment (Gillham, 2000; Hayes, 2000). Furthermore, the aims of the project were continually referred to so as to ensure that the schedule did in fact assist in answering the research question (Hayes, 2000). Once the schedule was formulated it was re-submitted to the above practitioner for a final critique.

### **Procedure**

One-on-one, face-to-face interviews were conducted with each health practitioner. This allowed for a level of privacy which sought to encourage participant openness and influence their willingness to share personal viewpoints (Hayes, 2000; Parker, 2005). The interviews were conducted in the participant's office at a time which was convenient for him or her, given their practice hours and the extent of their caseload. Furthermore, interviewing participants in a familiar setting sought to increase the level of comfort experienced, consequently impacting on their readiness to engage with the researcher (Babbie & Mouton, 2006). The duration of the interview was equivalent to one of their consultation slots, lasting approximately 20 minutes. This was so as to cause as little inconvenience to their working day as possible (Gillham, 2000). However, most participants (eight of the 12) became engaged in the process and in these cases, the interview lasted approximately 30 minutes. The

researcher's attempt to prevent inconvenience sought to further encourage the participant's overall compliance with the research process.

The researcher introduced herself to the participant and explained the purpose of the study after which an information sheet and a consent form were handed to the participant. Once the consent form had been signed, the researcher commenced with the interview. The interview was recorded with a dictaphone. At the end of the interview, time was provided for the participant to ask the researcher any questions they may have had about the study. The interview was then closed by thanking the participant for his or her participation.

### **Data Analysis**

The interview data was analysed using thematic analysis. This form of analysis assists in organising the data in great detail, which consequently allowed patterns found within the data to be identified, analysed and reported (Aronson, 1994; Braun & Clarke, 2006). Given that the researcher was specifically interested in knowing what the participants thought about screening for PND, it was unnecessary to analyse the nuances in the participants' tone of voice and style of language as one might in a study which is descriptive in nature and/or concerned with the participant's discourse or narrative. The current study solely required an understanding of which themes exist and which appear to be most prominent. The analysis involved the following steps:

- (1) The interview was transcribed, allowing the researcher to familiarise herself with the data. She then read and re-read the transcripts.
- (2) A template was created from the literature review including additional themes and subthemes as a result of the content of the transcripts.
- (3) Data was systematically coded and collated into the themes and subthemes.
- (4) Findings were then discussed according to the established themes with the formulation of recommendations for future research and practice.

### **Ethical Considerations**

Informed consent was obtained from all participants to ensure they fully understood the requirements of the study. Thus to ensure fully informed consent information sheets were provided to all participants (see appendix B). Participants were informed that all data collected from the study would remain confidential and that only the researcher and her supervisor would have access to this data. Participants' identities were kept private through the use of pseudonyms. These pseudonyms were used when using quotations to reflect the

findings. All recordings and transcripts were stored on a CD as well as saved on the researcher's laptop requiring a password. All participants were informed that they were not compelled to participate in the study and that if they choose not to participate there would be no penalty. They were also told that they may withdraw at any point. There were no overt risks to participating in the study, nor were there any immediate benefits. Minor benefits may include the feeling of being heard and enjoyment of interacting with the interviewer. Possible future benefits may include an increased awareness of PND and the need to screen for it as well as the development of a PND screening protocol and referral system.

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## **CHAPTER 4: RESULTS AND DISCUSSION**

Analysis of the participants' attitude towards and experience of screening for PND reflected both consistencies and differences in relation to international literature on screening for this illness. In part, the South African context, and the differences between its healthcare system, available resources, prevalent healthcare issues as well as the medical model from which it operates, and the systems in which previous research in this area has been done, assisted in providing the basis of understanding the differences in opinion as well as the formulation of recommendations for increasing the likelihood of screening. The required professional training and qualifications obtained, largely assisted in explaining cases where the participants' views mirrored that of the literature.

### **Practitioner understanding and awareness of PND**

Participants' knowledge of PND was consistent with the descriptions of this illness as offered by research investigating PND symptoms, consequences and onset period (Olson et al., 2002; Perfetti, Clark & Fillmore, 2004; Sit & Wisner, 2009). Their acknowledgement that the majority of mothers will experience the 'baby blues' was consistent with the high prevalence rate of this condition (Leitch, 2002). Awareness that short term depression is common in the first few days post giving birth should contribute towards their awareness of PND and consequently monitoring the mother over the postnatal period.

To a greater or lesser extent, all health professional qualifications will provide training on common mental health issues associated with general medical conditions, depression being a common one. According to Ogrodniczuk and Piper (2003) the symptoms of PND are not dissimilar to that of major depression and consequently should assist health practitioners to detect cases of PND in their practices.

Consistent with participant opinion, despite the fact that health practitioners appear to have an understanding of the severity of PND and are aware of its existence, formal screening remains for the most part uncommon. According to G1:

“We all should be doing it [screening] because one in ten women will have PND, so one in ten is common actually. If you think you are screening for cancer of the cervix, which is a lot lower prevalence, I mean, ovarian, which is like one in a hundred, and breast cancer, which is one in ten, and we screen for those. So we should all be screening for PND.”

As a result, PND remains largely undiagnosed and consequently untreated (Gausia, Fisher, Algin & Oosthuizen, 2007; Perfetti, Clark & Fillmore, 2004). This implies that health practitioners are not truly aware of the prevalence of PND. According to a participating gynaecologist, this prevalence rate is likely to be greater than assumed given the insufficient use of validated diagnostic practices as well as mothers being able to successfully conceal depressive symptoms.

Given this commentary, it should be questioned as to why health practitioners are more likely to conduct formal screening for medical conditions which are less common than PND. The two major concerns here relate to the lack of emphasis placed on PND as well as the poor follow-through of awareness to action and as a consequence the number of cases which remain undetected.

### **Screening for general medical conditions**

The results clearly indicated that participants were not only aware of the necessity to screen for general medical conditions as with screening for cancer and diabetes but were consciously implementing the appropriate methods of detection (Moturr-Pilson, Snow & Bartlett, 2001; Rhodes et al., 2006). Participating gynaecologists commented that they were frequently screening for breast and cervical cancer, whilst paediatricians were assessing dip-stick urines and screening for thyroid stimulating hormones in babies. General practitioners were screening for a variety of conditions, two of which included cholesterol and high blood pressure while clinic sisters were concerned with birth weight. The conditions commented on reflected that they were strictly screening for physical conditions specifically within their professional scope of practice, while no reference was made to screening for mental health issues. This narrow scope of practice is indicative of the increasing specialisation of medicine in general (Moturr-Pilson, Snow & Bartlett, 2001). Health practitioners solely focus on medical issues relating to their profession as opposed to sharing the responsibility of diagnosing and treating conditions which may fall outside their discipline. This has implications for missed opportunities for screening and detection.

In the case of PND, this is concerning given its status as a mental health disorder and that consequently it may be overlooked. In conjunction with this concern is the added issue that only health practitioners concerned with the physical wellbeing of either the mother and/or her infant will be exposed to the mother during the PND onset period (WHO, 2010). The likelihood of the mother coming into contact with a mental health professional, such as a psychologist or psychiatrist, is unlikely unless through practitioner or self-referral.

Practitioner referral is common in cases where the practitioner feels unequipped to manage the case or does not believe it to be their responsibility while low levels of self-referral are largely as a result of the stigma attached to depression and wanting to present as a competent parent as well as the mother's perception of her mental health (Olson et al., 2006; Perfetti, Clark & Fillmore, 2004).

The participants framed screening in terms of the factors which were likely to increase the probability of screening, as opposed to the literature which focused on the barriers hindering detection. In the approaching discussion regarding PND screening the opposite was found to be the case in that practitioners readily relayed the obstacles they faced. The positive manner in which detecting general medical conditions was framed again highlights the emphasis health practitioners place on maintaining focus within their scope of practice which consequently is concerning in terms of the lack of attention given to mental health issues such as PND.

The barriers to screening were both consistent with and different to those presented in the literature. Participants' views relating to practicality of screening and treatment availability mirrored that of research relating to the two selected conditions, diabetes and breast cancer (Moturr-Pilson, Snow & Bartlett, 2001). Work pressure as a result of the limited time and short appointment duration negatively impacted on the likelihood of screening occurring while the availability of treatment in the case of a positive diagnosis sought to increase the likelihood of screening. Furthermore, consistent with the literature was the emphasis placed on prevention and early detection with the hope of minimising medical complications and increasing the likelihood of improved wellbeing and quality of life (Smith & Haynes, 1991; Whitford, Lamont & Crosland, 2003). Evidence of this is apparent in a comment made by GP2:

“A lot of our patients that we see are totally healthy, and I just see them to screen. So our philosophy is find things before they happen. So we do a screening type of approach to our checkups. We do our pap smears, refer for mammograms, screen for cholesterol and all those kind of things.”

This was echoed by GP3 who said: “I do a lot of screening because I do a lot of preventative health checks.” Lastly, a family history of a condition was another factor consistent with increasing the likelihood of screening (Smith & Haynes, 1991). According to P1 “If there's a

family history of asthma and allergies you might do bloods and skin tests to actually pinpoint the specific trigger for asthma.”

Barriers specifically communicated by the participants largely related to the quality of the screening method itself. Qualities such as cost-effectiveness, efficiency, reliability and validity increased the likelihood of screening using a formalised tool or method. Evidence of this was apparent in a comment made by P2 who stated that in order for her to successfully screen for general medical conditions:

“It [the condition] must be a problem that’s prevalent and relevant. It must be able to have a repeatable screen test, which has been proven to work in robust trials, and so on. And there must be treatment available.”

Similarly, P1 stated that:

“Screening, in simple terms, has to be cost-effective. You know, it can’t take up too much time, or in terms of blood investigations, can’t be too expensive. It has to be common enough that the screening is worthwhile, because you now pick up enough patients who are going to benefit from it. And there’s got to be an intervention at the end that you can offer.”

The former two qualities speak to practitioner concern regarding time and financing while the latter two qualities address the participants’ need for a tool which has a repeatable screen test given the concern associated with false positive and false negative scores.

In contrast, the barriers focused on in the literature were largely practitioner-related (Moturr-Pilson, Snow & Bartlett, 2001). The prominence of barriers such as scepticism regarding screening protocol, practitioner oversight as well as conscious decision making regarding screening for prevalent conditions, highlight the differences which exist between the health care systems of developed and developing nations. Practitioners from either system experience different barriers as a result of the resources at their disposal.

### **PND screening practices**

It was concerning to note that none of the participants had implemented any formal PND screening measures in their practices given that the literature had indicated that the use of such measures would improve the detection rate (Heneghan et al., 2000). Furthermore, the

fact that only four of the twelve participants were aware of the EPDS has implications for training.

Given the extent of agreement across all participants, it appears that emphasis should be placed on the manner in which mothers are dealt with during the postnatal period. Participant opinion was consistent with Paykel and Priest (1992) who indicated that practitioners who exhibited sensitive, non-judgemental qualities were more likely to encourage patient disclosure than those who did not. This is evident in the following comments:

P3: "It just depends how you express yourself and how you approach the patient."

GP1: "I don't know that I would ask specifically, but it is one of those things that you pick up. So I wouldn't maybe say to her "how are you feeling now after having your baby?", instead I tend to just in the back of my mind, think of the points or the scales that I want to talk about."

P2: "I'm not that direct. Because I think a lot of moms come in here and they want to be seen to be coping, that everything is fine. So it's: are you getting sleep? How is the breastfeeding going? Are you coping with baby, and have you got help at home? So ja, lots of indirect questions, but I never kind of say, how's your mood?"

A minor distinction was noted in that the participants stressed never asking the mother directly about her wellbeing while the literature encouraged directive questioning with a psychological focus (Paykel & Priest, 1992). Possibly the combination of a sensitive interviewing style along with directive questioning might improve practitioner identification of PND.

For the most part, participating gynaecologists' screening practices mirrored those found in the literature. Consistent with LaRocco-Cockburn et al. (2003) was the use of patient history gathered over the perinatal period as a baseline from which to judge change in mood state. This is reflected in the comment made by G3:

"What I normally do is I sort of gauge the patient. I know most of my patients very well after nine months, so I can easily pick up if I can see there's a problem. And if I pick something up, then I would ask them."

Given that all other participating practitioners, possibly with the exclusion of general practitioners, only come into contact with the mother during the postnatal period, this baseline could be advantageous in terms of gynaecologist detection of PND. Furthermore, this period of time also allowed for the development of a trusting relationship between mother and gynaecologist which should encourage disclosure of sensitive information.

Questions developed as a result of practitioner frame of reference regarding depression was another common screening practice consistent with LaRocco-Cockburn et al. (2003). A minor distinction was that the participants used their frame of reference to ask indirect questions as opposed to the direct questioning about mood state as indicated by the literature. Given the stigma attached to depression and its ability to maintain silence, direct questioning may possibly reduce this effect and increase the rate of detection.

LaRocco-Cockburn et al. (2003) highlighted the use of a short validated tool as well as a validated patient self report test in their practices while there was no indication of formalised screening tools being used by the participants. In addition to the screening practices commented on above, participants waited for the mother to volunteer information about her mental health. Given what is known regarding mothers' help-seeking behaviour, this approach may be poor at detecting PND (Perfetti, Clark & Fillmore, 2004).

Despite the lack of formal screening being used, in part the relationship described above and its ability to access personal information should assist gynaecologists in the identification of PND. However, practitioner judgement which mothers associate with feeling depressed and being unable to cope with their infant may negate the value of this relationship (Perfetti, Clark & Fillmore, 2004).

The screening practices used by the participating paediatricians were similar to that of gynaecologists using informal methods of screening, with similar diagnostic problems being reported. Consistent with Connelly et al. (2007) was the inclusion of observing the mother's behaviour and appearance. According to P3: "My approach is not very evidence-based – it's quite subjective. It's the way that the mom interacts with me." Despite the popularity of this method, it only detects severe cases of PND, given mothers' surface presentation (i.e. dressed neatly to present themselves as together and coping), consequently resulting in a number of missed opportunities. Furthermore, P2 commented that he would extend his screening efforts through organising to account for the practicalities of having a baby:

“A telephonic follow-up because remember, loading a baby in a pram and then coming to hospital, it’s a schlep for them too. So often it’s easier for them to pick up the phone and saying, ‘P2, the milk is flowing. I’m so much happier.’”

As with the current study, Connelly et al. (2007) highlighted that only a small percentage of practitioners were formally screening mothers for PND despite the report by Heneghan et al. (2000) indicating that formal screening is necessary for reliable diagnosis and can feasibly be implemented in paediatric settings. This possibly suggests that research findings have little effect on practitioner behaviour change which in turn has negative consequences for PND detection.

Similarly, in the case of clinic sisters, the implementation of formal screening procedures was uncommon despite the diagnostic value they present (Connelly et al., 2007). Instead the literature highlights how practitioners resort to informal screening methods which largely relied on the mother volunteering personal information. Again this was problematic given what is known regarding mother’s help-seeking behaviour during the postnatal period (Perfetti, Clark & Fillmore, 2004).

In contrast to this, despite still not using formal measures, participating sisters took a more proactive approach to screening. Similar to gynaecologists and consistent with Connelly et al. (2007), the sisters used the timing and frequency of their interactions to develop a close bond with mothers from which they were able to open up discussion regarding their emotional wellbeing post the birth of their child. According to S1:

“You get to know the moms pretty well if they come every week. And sometimes they come for their next baby as well, so you get to know them a little bit by the time they get here. So I think we pick up pretty well if there are big wobbles.”

Furthermore, two of the clinic sisters who had experienced PND had the added advantage of having real insight into the illness. This is evident in the following comments:

S3: “I guess, [I assess moms] intuitively, in a way, because it’s something that I went through myself. So I recognise the words that were going through my head when I had a small baby and was depressed”

S1: "I think it's because I was there as well- I had PND, severe PND with my first child- and I know the danger signs from what I went through."

This experience assisted them in flagging mothers they were concerned about, asking the necessary questions in a sensitive manner, with the hope of increasing the likelihood of disclosure and early detection.

According to the literature, it appears that general practitioners were more inclined to use formal diagnostic criteria as well as validated depression screening tools than other practitioners in their assessment of PND (Seehusen et al., 2005; Williams et al., 1999). Similarly, the participating general practitioners indicated that they would formulate their interview with the mother using criteria from a general depression inventory. Possibly, this approach may not be as reliable as that described in the literature. However, one general practitioner felt that administering a formal screening tool would diminish rapport with the mother consequently impacting on the level of disclosure.

As a result screening involved using their previous experiences of interacting with mothers and infants as well as their general experience of depression in their practices. This was reflected in the following comments:

GP1: "I think a lot of things that I have picked up, have been picked up along the way, and they are probably also more common sense type of things than actually having learnt skills."

GP3: "You build your own kind of frame of reference... I mean, I see so much depression. Also, if you've known the person before, it's also very useful because you can see how their functioning starts to become impaired."

The use of such methods for screening is possibly indicative of the lack of training in using a validated screening tool such as the EPDS.

### **Barriers to screening**

As echoed by the literature, despite practitioner awareness regarding the prevalence and severity of PND as well as their acknowledgement of their role in detection of this illness, screening efforts remain poor (LaRocco-Cockburn et al., 2003; Olson et al., 2002; Seehusen et al., 2005). This was reflected in the following comments:

S3: “If I started using one of the tools, I’m pretty sure we’d pick up more and we’d refer more.”

P3: “It’s hard because I know so little about it [screening for PND]. I’m actually feeling more embarrassed as the interview goes on.”

G1: “I know there is a postnatal depression scale that you can use. I don’t use it, but one probably should be using it.”

Furthermore, as a result of frequently screening for general medical conditions, it could be assumed that they are au fait with the act of screening and consequently should have little problem implementing some form of PND identification procedure in their practices. This however was not the case, with the above comments reflecting the need to explore the specific barriers relating to screening for PND.

On the whole the major barriers expressed in the literature mirrored those communicated by the participants. Consistent with the literature all professional groupings commented that time was a major barrier to screening (Connelly et al., 2007; Heneghan et al., 2004; LaRocco-Cockburn et al., 2003; Seehusen et al., 2005). The literature associated time constraints with other demands taking precedence over screening, a lack of time to offer suitable post-screening counselling as well as discuss PND-related matters, not to mention take an adequate patient history. Similar to the former association, the participants experienced the time pressure as a result of the fact that mothers had pre-established the purpose of the consultation. This was evident in the following comments:

P3: “It is difficult to find the time in the consultation because there are so many baby-related issues.”

S3: “I don’t know how the mom will react if I tell her that I think she’s got PND or that she’s depressed. So that’s sometimes a difficult one for me to open up in the check-up, because again, she is not there because she feels sad. She is there for her breastfeeding or vaccinations.”

Added to this was the comment made by GP2 that: “people come with all kinds of other things, and then your time gets eroded.” Participants felt it was important to ensure their patient’s needs were addressed given they were paying for the consultation. This impacted on whether or not PND was discussed with mothers, let alone screened for.

Participants also explained this barrier in terms of the short consultation period as well as large caseload. Moreover, as a result of the extent of the healthcare issues which need addressing in the South African context, these two factors are unlikely to change. Thus it is unlikely that PND screening will be added to the physical examination routinely performed by health practitioners. If screening were to occur, practitioners would need to restructure and use their time more efficiently.

Previous research regarding training relating to screening and treatment was consistent with the opinions of participating paediatricians and clinic sisters (Heneghan et al., 2004; Connelly et al., 2007). All were in agreement that without training they felt incompetent to diagnose and intervene with a case of PND. Similarly, general practitioners felt they did not have sufficient knowledge regarding how to diagnose and manage this illness. This potentially has implications for South African medical training and program restructuring given PND’s prevalence in society as well as exposure in medical settings.

Over and above those barriers already highlighted, when compared with the literature, a few differences emerged. In contrast to the literature, participating gynaecologists believed that screening was not their responsibility (LaRocco-Cockburn et al., 2003). This was evident in a comment made by G3: “I think, because we kind of feel, once the baby is out, we’ve done our duty.” He added however that “strictly speaking, it is not that way.” He commented that despite knowing the consequences of PND, it remains an illness which no profession appears to take responsibility for. This difference can possibly be explained in terms of the participants’ belief that their duties end after the mother has given birth. The barrier of insufficient remuneration for additional work, in this case screening, only added to the weight of the barrier of responsibility. As explained by this gynaecologist: “You have a 15-minute appointment, and it’s not charged, so you are not going to make it a half an hour appointment for something that you are not getting paid for.”

From the paediatric perspective, consistent with Heneghan et al. (2004) and Olson et al. (2002), was that the medical problems of the infant took precedence over the mother’s mental health, hence screening was not considered a priority. This is evident in the following comment made by P2: “As a paediatrician, I’m primarily looking after the baby.” In the case where screening took place, it was surprising that financial remuneration did not present as a

significant barrier given that the mother and not the infant was the beneficiary (Heneghan et al., 2004) This could be understood in that an infant's wellbeing is largely dependent on their mother's ability to function and consequently paediatricians may be willing to invest time into their health (Heneghan et al., 2004; Olson et al., 2006).

Furthermore, medico legal responsibility as reported on by Chaudron et al. (2007) similarly acted as a boundary for the participating paediatricians. P3 explained that:

“A screening tool like that [the EPDS], if I had it, and it was a positive result and I suggested that they [the mothers] follow up [went to a psychologist] and they don't follow up, where does the responsibility stop then?”

In conjunction with the gynaecologists' comment regarding no profession taking responsibility for PND, this barrier becomes even more problematic to overcome. In order to overcome this barrier consideration should possibly be given to the development of a protocol specifically designed to manage PND.

Additional paediatric barriers not apparent in the literature included limited access to screening tools, insufficient knowledge regarding intervention as well as concern regarding treatment outcome. The former barrier may relate to the under-resourced health care system while the latter may be associated with the medico legal responsibility (Chaudron et al., 2007) as well as the lack of training received ((Heneghan et al., 2004)

Clinic sisters' opinions mirrored that of the paediatric literature in relation to the barriers associated with access to screening tools, the infant being their primary patient as well as treatment outcome (Connelly et al., 2007). Treatment outcome in conjunction with the uncertainty of how to manage a case of PND appeared to be a major concern for participants as is reflected by the following:

S3: “If it just means giving somebody a questionnaire to fill in, the question is what do you do if you come up with a mom who's got a very high score. It's a little bit like getting somebody with an HIV-positive result: you can't just say, oh, here's your score. Off you go.”

S3: “You get somebody with a high score, and I don't always then know where to go. Because, do I send them to PNDSA? Do I send them to a psychologist? Sometimes,

they don't want to go to a psychologist. Sometimes, you send them to a GP and they are not very sympathetic. They don't want to go straight to a psychiatrist.”

In contrast to paediatricians, financial remuneration appeared to be a significant barrier for participating clinic sisters. S1 highlighted how the barrier of remuneration is closely associated with that of limited time:

“When we were consulting without a time limit, we had a longer chat to the moms, giving them the opportunity to talk. So the consultation would be, especially for a new mom, sometimes 45 minutes. Now, we are doing paid consultations, so you need to watch the clock.”

The possibility of damaging rapport through administering a formal questionnaire appeared to be a significant barrier for participants. S2 believed that: “If it is a very, very fragile mom, they don't want to be interrogated with a lot of almost paperwork.” Barriers unique to the literature included the cost of mental health professionals as well as insurance options limiting treatment (Connelly et al., 2007).

In terms of general practitioners, damaging rapport similarly acted as a significant barrier for participants. Consistent with the literature was practitioner concern regarding their knowledge of PND and consequently being able to sufficiently screen for it (Paykel & Priest, 1992). This was reflected by GP3 who stated that: “qualification-wise, I don't know how qualified we are. We certainly don't have a lot of time devoted to it at an undergraduate level.” This was partly surprising given that general practitioners are trained to work with depression and are often a source of referral in cases where depressed patients cannot afford to see a mental health professional.

Lastly, not considered an actual barrier but rather an explanation as to why general practitioners may not in fact be screening was explained by GP2 as: “The fact that I don't actually see the patient at the right, appropriate time [to screen]. She commented that they often only see the mother for a yearly check-up which may be after her experience of PND.

### **Practitioner opinion regarding screening**

It was clear that each professional grouping was capable of taking some responsibility for PND be it through screening, treating or referring possible cases while commenting that other professionals may be better suited to certain contributions given their time, qualifications and

patient preference. No one participant claimed full responsibility for total management of this illness. This possibly highlights the need for a collaborative effort amongst professionals. Combined effort may consequently lessen the number of missed opportunities for screening as well as improve treatment options.

### *Gynaecologists*

Consistent with Bennet et al. (2009), participating gynaecologists believed that a reasonable knowledge of PND was necessary for screening as without the ability to treat or refer, the patient's wellbeing may be at risk. This has implications for a practitioner's medico-legal responsibility.

Not mentioned by the literature but recommended by G1 was that an interest in psychiatry may be beneficial if a gynaecologist was to screen for PND within their practice. This is a reasonable expectation given that PND is a mental health issue which the discipline of psychiatry has been trained in. However, as explained by Bennet et al. (2009) the gynaecological setting has not traditionally been associated with mental health care and consequently practitioners may not feel competent to screen for PND. This thus has implications for training.

Despite this, gynaecologists believed they and clinic sisters were well positioned to screen given the amount of time they spent with the mother. This was consistent with Sit and Wisner's (2009) finding that postpartum gynaecological checkups fell within the PND onset period. Furthermore, gynaecologist's opinion regarding clinic sisters was supported by the WHO's vaccination schedule (2010) which was indicative of the number of times the mother should be in contact with a clinic sister post birth, consequently presenting multiple opportunities to screen. G3 also added that he would be more likely to screen for and manage PND if he had access to a practice nurse:

“It should be the practice nurse [who screens], but the reality is, most of the time there isn't a practice nurse. If you look here, there's a secretary and me. The secretary is not medical, so she wouldn't know what to ask.”

All the participants indicated that if time and work pressure were less of an issue they would be more likely to engage in screening for PND themselves.

In terms of patient preference, consistent with Yonkers and Chantilis (1995) gynaecologists believed that the mother would want to be screened by someone they had

developed a close relationship with was echoed by G2: “I think the patient’s preference would be the one that they are familiar with, so, I suppose, the gynaecologist if you’ve got a good rapport with your gynaecologist.” This was supported by LaRocco-Cockburn et al. (2003) who highlighted that the nature of this relationship was likely to result in disclosure of personal information allowing for the detection of PND. Thus, given the amount of time spent together during the antenatal period, the gynaecologist appears to be in a good position to develop such a relationship and consequently screen the mother for PND.

In the American health care system, many women appoint their gynaecologist to be their primary health care provider (Bennet et al., 2009; Yonkers & Chantilis, 1995). This however is not the case for private health care in South Africa where the general practitioner for the most part is viewed in this role. This is possibly evidence of why gynaecologists will use the general practitioner as their first point of referral. This is considered a feasible referral given the cost of consulting a psychiatrist or a psychologist. This is reflected by G3: “I don’t mind starting a patient on medication if I think they need it, but I would always refer out to a GP, or if it’s very serious, to a psychiatrist, depending on the degree of depression.” G1 echoed this opinion while highlighting the mother’s financial reality attached to seeing a psychiatrist: “Ideally, it should be a psychiatrist. But the reality is, a psychiatrist is R1500 for a consult. So the reality would be a GP.” Additionally, the stigma attached to consulting a mental health professional often discourages individuals from seeking treatment.

### *Paediatricians*

The main reason for participants deferring screening responsibility to other health practitioners relates to their view that the child is their primary patient and consequently consultation time should be dedicated to their health (Heneghan et al., 2004; Olson et al., 2006). This reason was further substantiated by the fact that the participants felt that the field of paediatrics still needed to achieve its own focus before addressing matters such as PND, which fall outside of its scope. This was reflected by the following comments:

P1: “I don’t actually deal with the mom. I deal with the baby. So if I’m concerned, I’ll definitely send the mom back to her gynaecologist. Because I won’t treat that, the mom is not my patient.”

P3: “I see myself as the screening person and the referral on person. And frankly, I don’t think as paediatricians we’ve sorted out paediatrics. I don’t know that we can

take on something else. I can alert the relevant people to red-flag things that I pick up within my practice, but I don't really feel it's my role to drive that."

The participants thus sought to defer responsibility to those who they believed had the time and the necessary qualifications as well as who had established some bond with the mother.

Many of the participating paediatrician's opinions were similar to those of the gynaecologists. Participants' belief that clinic sisters were in a good position to screen for PND was in accordance with the WHO's vaccination schedule (2010). This possibly would allow the clinic sisters to establish a baseline of the mother's mental state during the postpartum period from which to judge the development of PND.

In terms of qualifications, they indicated that mental health professionals were in the best position to screen given their knowledge of mental health issues such as PND. However, given that the Partnership for Women's Health Program was successfully able to train health practitioners to competently screen for PND the barrier of knowledge should be irrelevant (Baker-Ericzen et al., 2008). Given that mental health is outside their scope of practice, health practitioners may experience a sense of inadequacy and consequently pass responsibility onto those they believe to be more competent. This inadequacy is likely to fall away with training.

Furthermore, the type of qualification appeared as a significant factor given the medico-legal responsibility attached to screening and the consequent responsibility of managing patient outcomes (Chaudron et al., 2007) This option was problematic given that mothers were themselves unlikely to come into contact with mental health professionals during the PND onset period.

For the same reasons as provided by Yonkers and Chantilis (1995) and LaRocco-Cockburn et al. (2003), participants believed patients would prefer to be screened by their gynaecologists. Frequent contact and knowledge of the practitioner would enable personal disclosure. Furthermore, the paediatricians themselves were disinclined to treat the mothers given their expertise and consequently felt referral to a mental health practitioner such as a psychiatrist or a psychologist would be best.

P3: "Because I have such a poor feel of how to go on, I refer onwards. I do make a note of it in the folder, in my notes. So when they come back, I will see, and if I think they are relapsing, I will contact their health-care provider. But I don't take that responsibility as well. As a paediatrician, I'm primarily looking after the baby."

P2 added that “I’m quite happy to suggest medication, and I keep it kind of simple because I’m not a psychiatrist or a psychologist.” He commented however, that it would be important to have a good relationship with the mother and possibly knowing her from previous pregnancies would assist in suggesting medication.

It is important to note that participant deferment of screening responsibility did not mean that they were unconcerned about the mother’s mental health as, according to Heneghan et al. (2004) and Olson et al. (2006), paediatricians are aware of the correlation between mother and child wellbeing. This was evident in the above the expression of care in the above two comments as well as the following:

P2: “I think it is part of my routine. It’s like me talking to moms about vaccination. I want to know how mom is doing and try and assist her as I can to help the baby.”

P3: “You are caring for them as a unit, mother and child, and dad to some extent.”

Not mentioned by the literature was that participants did not want to interfere with the relationship between mother and gynaecologist and consequently believed it in their best interests to refer back to the gynaecologist if their concern warranted further attention. This was exemplified by the following:

P3: “But at six weeks, ja, I think part of the paediatric assessment should be how is mom doing. You know, they also have their six-week gynaecologist check-up at the same time, so you don’t want to kind of interfere with what the gynaecologist is doing.”

As with gynaecologists, participants drew attention to the fact that in cases where mothers have had multiple pregnancies, they too have the ability to establish a trusting relationship as well as a baseline of her wellbeing. The effect of these two factors may be similar to that commented on by LaRocco-Cockburn et al. (2003). Consequently, this may have implications for the level of screening responsibility currently assumed by participating paediatricians. This implication is congruent with Olson et al. (2002) who suggested that the role of paediatrician can be seen as two fold.

*Paediatric nurses/Clinic sisters*

Clinic sisters believed they were in the best position to screen for PND as a result of time spent with the mother, frequency of visits and their level of psychosocial concern. This belief was reflected by the following:

S1: “In my position, where I work for myself, I pretty much work on appointments so I can slot an appointment for an hour if it needs be. They [other medical practitioners] don’t always have that opportunity because they deal with a lot of emergencies in between, or unforeseen circumstances.”

S3: “We really see them every week for the first month or so. And then after that, it’s sometimes only every two weeks or every four weeks that we see them. But we encourage them to come for the first six weeks. We encourage them to come every week. This allows us to observe and check-in with mothers frequently.”

Consistent with Minde, Tidmarsh and Hughes (2001), participants spent more time (twice as much) with mothers than did other practitioners. As indicated, this allowed for discussion outside of the infant’s routine check-up to include enquiry regarding the mother’s wellbeing (Minde, Tidmarsh & Hughes (2001). Furthermore, consistent with Connelly et al. (2007), the number of visits required by the vaccination schedule allowed for extensive observation during the postnatal period. The impact of this consistent interaction was likely to result in the development of a trusting relationship between mother and clinic sister which consequently may encourage the mother to feel comfortable disclosing information.

This relationship is further strengthened by the fact that patients experience nurses to be less threatening than doctors (Minde, Tidmarsh & Hughes, 2001). This was consistent with participant belief that mothers were more inclined to discuss their struggles with them given that they found their consultation setting to be less intimidating than that of a medical doctor. This was exemplified by the following comments:

S3: “So we do build a very close relationship with many of our moms, that they feel they can trust us and tell us how things are going. So I guess anybody who is seeing the moms on a regular basis, like the well-baby clinics would be good to screen.”

S2: “I think it’s because you don’t see them [the clinic sisters] as the doctor, so the moms are a little bit less intimidated. It’s mainly women, and it’s mainly mothers themselves [in the waiting room]. Here, a lot of moms are in the same situation.”

This has implications for the way in which medical doctors are perceived and consequently should be considered in relation to training on interviewing and counselling skills.

Not mentioned in the literature, but what participants claim to have contributed to their setting and its respective effect, was the presence of other mothers likely to be having similar experiences. Shared experience is known to be powerful in terms of its ability to extract information. Despite this, the stigma attached to depression is likely to manifest in such a setting, where mothers want to appear as competent parents (Perfetti, Clark & Fillmore, 2004). Additionally, according to Ussher (2004), mothers are also more likely to open up to clinic sisters as they perceive them to be on a relatively equal footing. Clinic sisters thus appear to meet the patient’s preference for screening.

According to the literature, nurses showed great concern for psychosocial functioning and dedicated a large portion of the consultation to creating a global picture of the mother’s mental health (Minde, Tidmarsh & Hughes, 2001). This possibly explains the emphasis participants placed on screening being done by a mental health professional with a specific interest in PND as well as wanting to refer the mother to a psychologist who they trusted and felt competent to manage the case. The following is illustrative of their referral practices:

S2: “I would like to refer to a psychologist, and mainly one that I feel would be safe and that I can vouch for. So not just any psychologist, but someone that’s interested in the field of babies.”

S3: “So I send them either to a GP or straight ... if they are happy to do so, straight to a psychologist. It also depends on medical aid issues: sometimes you have to go via your GP.”

S1: “I refer back to the gynaecologist to start off with, just to see that we are maybe physically not missing something as well. Because a lot of these emotional triggers can be associated with a physical disorder.”

Furthermore, consistent with literature, participants highlighted the distinction and power differential between clinic sisters and general practitioners (Minde, Tidmarsh & Hughes, 2001). The consequences of this distinction can partly be seen to contribute to the missed opportunities for screening as seen by participants who described limiting their screening involvement for fear of doctors believing them to be stealing their patients. This was evident in the following comment:

S2: “From our point of view, we are the sisters and they are the doctors, and you can’t go up against that. That’s a fight on its own. Then you are going to have to spend a hundred percent of your time to fight that fight, and we feel, rather fight the fight with the mom.”

Consequently this has implications for practitioner relationships and the need to improve communication between health professionals, with the hope of working collaboratively in the best interest of the mother. Achieving this may be difficult as according to the participants, each health practitioner already has a pre-determined role to fulfil which consequently discourages them from taking responsibility for PND. This was clearly expressed by S1:

“The gynaecologists do see the moms at six weeks and the paediatricians see the moms at six weeks, but, of course, the paediatricians are more concerned with the baby, and the gynaecologist is not necessarily interested in what’s going on in the mom’s head. And I don’t know how often the moms would go to their GP at that time.”

#### *General practitioners*

Participating general practitioners, similar to the other health practitioners believed that clinic sisters were in the good position to screen as a result of the length and frequency of their consultations (Minde, Tidmarsh & Hughes, 2001). Not mentioned by the literature, participants commented that clinic sisters had a greater flexibility in terms of their work hours. This possibly explains them being able to spend more time discussing the mother’s mental health. This was made apparent in the following opinions:

GP1: “I think time-wise, it would be difficult with a gynaecologist because they have a very busy schedule.”

GP2: “And time-wise, I don’t think the paediatricians are going to [be able to screen] and because they don’t have the expertise either, and I don’t think they would get involved.”

GP3: “I don’t think the paediatrician because, you know, they really don’t have [much] to do with the mother. She is looking at whether the hips are clicking or whether he’s obese. Most women just see the gynaecologist to have the baby - and that’s it, they bugger off. Or they don’t necessarily see a gynaecologist; you don’t have to see a gynaecologist ever again, once you’ve had your baby.”

Participants did not believe that they were in a good position to screen given that they were unlikely to see the mother during the PND onset period and/or were not involved in the delivery process. This was evident according to the following practitioners:

GP1: “We see patients early in pregnancy and then often, for the pregnancy we refer them on because we don’t do delivery. So we refer on to a gynaecologist. And they then often see the gynaecologist for their six-week check. So we don’t see them immediately afterwards. We tend to be a practice where they come annually for their check-up, so we often don’t see them, unless they’ve got a problem or develop a bladder infection.”

GP2: “The patient doesn’t come to me really in that postnatal phase because they are either at the paediatrician, or they are at the clinic itself, or they are planning to cope for themselves.”

This may possibly explain Gunn, Lumley & Young’s (1998) concern that general practitioners are not taking advantage of their position to screen. Furthermore, this belief was in contrast to Buist et al. (2005) who commented that general practitioners would examine 90% of women during the postnatal period. Despite their position however, general practitioners believed they themselves or a psychologist was best suited to screen for PND based on their respective qualifications. They acknowledged that it was unlikely that a psychologist would become involved unless through referral.

In terms of patient preference, participants commented that mothers would prefer to be screened by general practitioners as a result of their longstanding relationship. This was highlighted by two of the participants:

GP3: “I think the family physician is the best because he is the one who sees the patient in her environment and in her world. He knows the patient’s world.”

GP1: “Somebody who has a relationship with that patient, who they feel that they can unburden to.”

This was consistent with Paykel and Priest (1992), who emphasised the value of the continuity of this relationship and its effect on patient disclosure. For this value to be realised however, general practitioners would need to see the mother during the postnatal period. Participants added that having access to an extensive medical history provided them with a baseline from which to assess the mother’s mental health. As with gynaecologists, (LaRocco-Cockburn et al., 2003) this knowledge should assist in the detecting changes in the mother’s emotional state over time.

Consistent with Paykel and Priest (1992), participants indicated that depending on the severity of the case, they would treat the mother themselves or refer on to a mental health professional. As a result of the stigma attached to depression they were cautious regarding referral (Perfetti, Clark & Fillmore, 2004). The referral practices were reflected in the following:

GP1: “If it’s somebody that I can’t handle at my level, it would then need to go onto a psychologist.”

GP2: “I think she should come to the GP. Because I think, as soon as you expose her to psychiatry, because I mean, that is a psychiatric disorder then the mother would definitely veer away.”

### *Summary*

Participating paediatricians provided a good overview of the complexities associated with taking responsibility for PND. They commented that each profession involved with the wellbeing of mother and child is faced with a number of challenges in terms of caring for their respective patient. They highlighted that some professions have more time than others to

engage with and observe the mother, while others are more qualified to screen and treat. The description provided by one of the paediatricians below is indicative of these challenges and the difficulty in determining where the responsibility for screening lies.

P2: “You know, they [the breast feeding clinic] are not in a very stressful situation, so they probably have the best time. You know, I’m looking at baby and thrush, talking about vaccines and organising this and what milk we are using, so it’s kind of a bit loaded. Gynaecologists should have more time, but I think it’s kind of: “how are you? How is the scar? Caesar is doing well? Oh, baby looks great! We did a great job” – and you’re out of there. I don’t think they spend a hell of a lot of time. Moms are not going to GPs at that point in their lives. They go to their gynaecologist, they’re going to their well-baby clinic and they come and see the paediatrician. So to squeeze in a GP visit is difficult, because time is short and life is tough.”

### **Suggestions to increase the likelihood of screening**

It was evident that many of the suggestions sought to manage the impact of the barriers experienced by participants as well as to improve screening practice. The simplicity and achievability of these suggestions speaks to the over-burdened health care system and possibly its inability to make complex adaptations or additions. Given the nature of their suggestions, one should question why in fact participants themselves have not implemented the necessary changes to improve screening? This could possibly be explained by the exclusivity of practice and no profession feeling responsible for PND.

As suggested by the literature, participants all requested access to a standardised, reliable screening tool with which they confidently could measure PND within their practices (Kendall-Tacket & Kantor, 1993; Mishina & Takayama, 2009). They requested the tool be efficient and easy to use. GP1 described the tool as follows:

“I think it has to be a screen that’s not too involved and complicated. So it has to be quite compact. Otherwise, one is going to carry on using one’s own kind of initiative and intuitive questions that we have always asked. [It needs to be] efficient and easy to apply, at my fingertips, that I could reel off the internet or pub-med.”

The need for such qualities is possibly best explained in terms of their heavy caseload requiring timely management as well as not wanting to damage patient rapport by

administering a long questionnaire. Furthermore, with the addition of PND screening into what is already considered a full physical examination, efficiency becomes even more pertinent. A minor distinction from the literature was that participants also highlighted the need for a cost-effective screening method. This could relate to the under-resourced healthcare system in which they operate and the improbability of receiving funding for a costly screening method.

The suggestion of training was another recommendation consistent with the literature (LaRocco-Cockburn et al., 2003; Mishina & Takayama, 2009). Slight differences were noted in terms of the type of training requested. For the most part, participants sought training in tool scoring and administration while clinic sisters requested counselling skills be offered. S3 commented that this would assist them in knowing “how to approach the mom and how to read the situation.” Counselling ability may help to overcome the barrier of managing a diagnosis. S1 specifically commented that: “Definitely a workshop to start off with, so if they can give us a little more of a broader spectrum of what we are dealing with, and just the basics- not just the basic nursing background.” She reflected on the distinction between the nursing profession and that of the other medical practitioners involved in the care of mother and infant (Minde, Tidmarsh & Hughes, 2001), highlighting the need for consistent training across all groups. Ultimately, as indicated by the Connelly et al. (2007), training outcomes, in terms of the skills obtained and confidence gained, may help improve screening competency and consequently increase the rate of detection.

Not mentioned by the literature was the issue of trainee non-attendance at PND-related workshops. This could be understood in terms of their busy schedules and not wanting to spend time on a topic outside their scope of practice. This non-attendance is concerning given the prevalence of PND and the number of missed opportunities for screening. This consequently has implications for the adaptation of medical training to incorporate information regarding PND as reflected by Seehusen et al. (2005). In order to overcome non-attendance, G1 recommended that CPD points be offered for participation. Furthermore, G2 indicated that: “I’m not sure if a workshop will help, because if I want to, I just open a textbook and read.” This is a reminder that learning preferences as well as time (in terms of practitioner schedules) are to be accounted for when designing training (Kutcher et al., 2003).

A major request made by participants, yet which only appeared to have minimal support from paediatric literature, was the need for information regarding PND support structures for sufferers as well as educational material in the form of pamphlets (Heneghan et al., 2000). The following comment made by P3 emphasises this need:

“I get visited every day by a rep or two... But no one from the PNDSA comes to see me. No one from Lifeline comes to see me. No one from MedicAlert comes to see me. It’s things that you actually need updating on, and they don’t visit doctors.”

Given the prevalence of PND and the likelihood of health practitioners referring cases onwards as a result of their possibly feeling unable to intervene, it was concerning to note this lack of information. The current existence of such groups and the availability of such materials (through organisations such as PNDSA) possibly highlight a gap in communication between health practitioners and support structures. As suggested by participants, a contact list of referral should be drawn up, possibly with the assistance of an organisation such as PNDSA.

An additional recommendation offered by the literature was that consideration should be given to screening style (Heneghan et al., 2000; Kendall-Tacket & Kantor, 1993; Paykel & Priest, 1992). According to Paykel & Priest (1992) screening methods as described are only truly useful if implemented by practitioners who are not only trained in the said instrument but have the necessary interviewing skills to discuss psychological issues such as depression. This applied to both nursing and paediatrics.

The set of skills for general practitioners are similar for gynaecologists, paediatricians and nurses given their shared purpose of accessing sensitive information regarding the mother’s mental health. Paykel & Priest (1992) found that certain general practitioners were better able to detect depression as a result of the manner and style in which they interviewed the mother. Qualities which appeared to encourage patient disclosure included eye contact, listening skills, not interrupting the patient, taking time to hear their story as well as directive questioning with a focus on psychological symptoms (Heneghan et al., 2000; Kendall-Tacket & Kantor, 1993; Paykel & Priest, 1992).

### **PND protocol and referral system**

Participating clinic sisters as well as general participants were eager to share their ideas for the development of a PND protocol and referral system. Possibly the former participant’s enthusiasm stemmed from their own personal experience of PND as well as the extent of their psychosocial concern for mothers. Both of these factors are likely to have contributed to the realisation that without such a system the barriers to screening will continue to result in

missed opportunities for detection. The latter participants' knowledge of depression and its respective consequences may have contributed to their reasoning.

A few of the recommendations offered by clinic sisters reflected concepts incorporated into the Partnership for Women's Health program (Baker-Ericzen et al., 2008). Their understanding of the value of including all health practitioners concerned with the wellbeing of mother and infant into such a program being the most pertinent. This was apparent in the following description:

S2: "Better to have like a hospital setting where you will have your gynaecologist, your breastfeeding consultant, your paediatrician, your sister and the psychologist, if you are so lucky that there's one in the hospital. And actually, discharge the mom with everybody's knowledge about the mom. The health-care team could identify it and then appoint someone maybe just to have follow-up with the mom afterwards."

None of the participants provided an explanation for how such a system would in fact operate in practice as was offered by the Partnership for Women's Health four stage process (Baker-Ericzen et al., 2008). It is one thing to have the theory from which to design a working model, however it is then necessary, to in detail, draw up the protocol and referral system. This process should include consideration of the responsibility of role players, all barriers to screening as well as resources available at one's disposal (Baker-Ericzen et al., 2008). So as to ensure discussion of all challenges and possibilities associated with such a program all health practitioners concerned with the wellbeing of mother and infant should be included.

The PWH model, if adapted according to the barriers and resources specific to the South African health care context, could possibly work. However, given the cost associated with multi-disciplinary teams (groups of professionals from diverse disciplines who come together to provide comprehensive care) in developing nations patients may be unable to afford such a service. It is however a good point from which to start designing a protocol and referral system even if only certain parts of it are initially adopted into our system.

What was recommended by the participants but not encompassed by the literature was the inclusion of the EPDS with the baby's growth chart. Hopefully by including the EPDS, mothers would associate the same level of importance with it as with the chart, increasing their awareness of PND. Furthermore it would provide practitioners with a reminder to screen them. This was evident in the following:

GP3: “No matter whether you’re dealing with a mother from Khayelitsha, from Sandton, from Bishops Court – from wherever – that mother guards that baby’s growth chart like gold. I think this scale that you have shown me [EPDS] will work very well, clipped to either of those two [vaccination chart or the breastfeeding booklet].”

Additional consideration should be given to this idea in terms of providing practitioners with a protocol for what to do in the case they detect a mother suffering from PND. Knowing they have a referral mechanism in place would help to encourage screening as well as address their medico-legal responsibility.

Another suggestion was educating parents during antenatal classes. This setting was considered beneficial as it provided the opportunity to educate both parents about PND early on in the process. Hopefully, it will result in shared responsibility between parents and practitioner in terms of monitoring the mother during the postnatal period, increasing the likelihood of detecting PND.

Clinic sisters also highlighted the importance of checking on the mother post her six week appointments with the gynaecologist and paediatrician. During this time practitioner contact with the mother lessens substantially. Consequently clinic sisters suggested the idea of home visits. This was evident in the following:

S1: “I actually believe that every patient, not just home delivery, should have somebody going to your house and have home visits to see how you’re coping. And not just come in to the clinic, because a lot times you [the mom] are on your best behaviour at the clinic.”

However, the gynaecologists highlighted that given limited staffing as well as the cost implication for both mother and health care system this idea would not be feasible.

A final recommendation, offered by P3, was that if collaboration were to occur it should involve the departments of gynaecology and psychiatry. The value to be offered by both departments is clearly evident, the gynaecologist having built a relationship with the mother and having established a baseline of her emotional wellbeing is well positioned to screen while the psychiatrist is trained to treat. P1 explains it as follows:

“The gynaecologist starts at nine months or at eight months, depending, and they’ve got that long perspective. I think they should be more proactive than what they are. Like with us, with paediatricians, we’ve had a combined conference between ICUs in the country this year. We see it as a priority, and when it comes to child health issues, I would proactively go out and see a psychiatrist and see a psychologist who have an interest in paediatrics. So the maternal half belongs to the obstetrician and the gynaecologist. I feel that they should be forming those ties between the departments.”

The inclusion of other practitioners however, would allow for multiple screening opportunities at different points in time. This should increase the likelihood of detection. Furthermore, involving only these two departments limits the mother’s opportunity to receive assistance from health practitioners they may feel more comfortable consulting with as a result of their relationship, qualification or setting.

Furthermore, consistent with Chaudron et al. (2007), G1 reflected that if a collaborative system were developed, involving those concerned with the care of mother and child where would the medical-legal responsibility lie? Once a mother had been identified as suffering from PND, he was apprehensive regarding the referral and follow up processes given that PND was an illness which no profession sought to own.

Many of these recommendations largely appeared to be feasible, however without practitioner willingness to participate in screening and work collaboratively, it is unlikely that they will be realised. These suggestions should thus be investigated further so as to determine the level of practitioner support as well as how they may be incorporated into a system which could improve the current rate of PND detection.

## **CHAPTER 5: CONCLUSION**

It is clearly evident that there are both similar and differing perspectives regarding screening for PND. However, one factor which remains consistent across all health practitioners is the fact that no profession is motivated to screen for this condition. In this study, motivation referred to educating mothers regarding PND, screening potential cases and where necessary referring them on for additional assistance. This lack of motivation is largely as a result of the barriers to screening as well as the exclusivity of practice.

The most common barriers included that of time, work pressure as well as a lack of training while the differences related to medico-legal liability, professional qualification and care for the primary patient being a priority. Further impacting practitioner ability to successfully detect cases of PND was the use of informal, invalidated screening practices. Exclusivity of practice related to the fact that all health practitioners were concerned with focusing their efforts on their discipline which for the most part excluded mental health conditions. Given the severity and prevalence of PND, this lack of motivation is concerning as it is likely to result in a number of missed opportunities for screening and consequently a poor detection rate. This as well as the stigma attached to PND which negatively influences a mother's help-seeking behaviour will result in the continuation of suffering.

In contrast to the above and interesting to note was the fact that all practitioners were supportive of routine screening for general medical conditions, reporting only minor to no barriers to screening their patients. This practice is promising for patients given the benefits associated with early detection. As a result of this support, the question of why this positive screening practice is not adopted for mental health issues such as PND must be asked. Both the lack of motivation as well as the relatively unconscious distinction health practitioners make between physical and mental health conditions possibly provides an explanation for this question and consequently has implications for both practice and future research.

Given that the majority of practitioners were not aware of nor had used any formal PND screening tool in their practices implied the need for training. Training could be in the form of a short workshop including basic instruction regarding scoring and administration of the tool. This would highlight the ease and time efficiency of screening, hopefully encouraging screening within their practices. Furthermore, it would allay any anxiety practitioners may have regarding their ability to screen. The workshop would seek to increase screening confidence, with the likelihood of increasing the rate of detection. Possibly if screening for PND were incorporated into the medical training degree, more weight would be placed on detection of this condition in medical settings.

Additionally, given the emphasis practitioners placed on sensitively working with mothers, basic interview and counselling skills used to retrieve and feedback sensitive information could be incorporated into the above workshop. Furthermore, practitioners should be encouraged to educate both the mother and her partner about PND during the ante and/or postnatal period depending on the timing of appointments. This would help to manage the stigma attached to depression and encourage mothers and partners to share in the responsibility of detection through seeking help of their own accord.

The use of formal, validated methods of screening for both physical and mental health conditions would help to alleviate a great deal of pressure on the South African health care system given the benefits of early detection as well as minimising the likelihood of false negative or false positive results. Hopefully, as a result, health practitioners would consequently only treat those requiring assistance, lessening the amount of time spent determining the diagnosis. Furthermore, the use of such screening methods may possibly help the South African health care system move towards a more preventative model of health care as opposed to a curative model of health care. This move would serve to reduce labour and medical costs, increasing the likelihood of medical practitioners screening for PND in their practices.

In terms of future research, the findings from the qualitative data collected for this study could be used to design a questionnaire to be administered to a larger sample (including all those health practitioners concerned with the care of mother and infant) to statistically assess the significance of the original findings. This would clearly establish the barriers to screening and consequently determine which recommendations were deemed feasible in terms of improving screening practice and increasing the rate of detection.

The fact that no profession where the practitioners have contact with the mother in the window period during which PND develops, is motivated to screen for this condition has major implications for the development of a PND specific screening protocol and referral system to be designed and implemented. For this to be realised, buy-in from all health practitioners concerned with the wellbeing of mother and child during the postnatal period is required. In order to determine the feasibility of implementing such a protocol, a model such as the Partnership for Women's Health Program could be researched in the South African context. It may be useful to conduct a focus group with a combination of all health practitioners concerned with mother and child so as to explore the possibility of a collaborative effort and the consequent development of a PND protocol and referral system.

Lastly, a similar study could be conducted in the public health sector given that one cannot assume the same barriers and recommendations for improvement to exist in this field. Conducting research in this sector is possibly more critical given the lack of medical resources and the nature of medical issues being dealt. In comparison to physical health issues such as the HIV/AIDS epidemic, mental health concerns such as PND take a backseat. It is thus probable that the number of missed opportunities for screening are greater in the public than in the private health sector and consequently require increased attention.

Of course, this study had limitations. One of the limitations of this study included the small sample size. This may have influenced the representativeness of the sample and consequently the ability to generalise the results to the whole of the private health care system from which the sample was drawn.

The participants' pressurized work schedule may possibly have influenced the nature of the information offered during the interview. Some participants appeared more rushed than others as a result of their heavy caseload. As a consequence they may have offered less detailed information, affecting the quality of data collected.

In terms of reflexivity, the fact that the researcher was relatively younger than the participants as well as not yet fully qualified as a health care professional may have influenced the quality and quantity of the data she was able to obtain. This however, did not appear to be problematic given the enthusiasm with which the participants responded, often exceeding the allotted appointment time.

The research does however provide insight into the attitudes and experiences of health practitioners towards screening for PND, shedding light on the barriers inhibiting screening as well as offering suggestions to improve the likelihood of screening being conducted in medical settings. If utilized, these findings along with that of further research in the field, may contribute towards the development of a PND-specific screening and referral protocol. This would hopefully serve to increase the detection of PND, positively impacting on the wellbeing of mother, infant and partner.

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## APPENDIX A: Interview Schedule

1. Are you aware of PND being an issue within families with newborns?
  - If you had to guess, what percentage of patients whom you see in this practice/clinic/hospital would you estimate have PND, or some form of mood change?
2. Could you describe the characteristics of a patient whom you might expect to have PND?
3. How do you feel about using health screening for health conditions in general; e.g., screening for chronic problems like asthma, diabetes or high cholesterol? That is, what are some reasons why you might or might not do so?

### PROBE FOR ALL OF THE FOLLOWING IF NOT MENTIONED:

- no time to screen
  - no time to treat if screening identifies problems
  - no treatment available if screening identifies problems
  - other priorities are higher (such as? \_\_\_\_\_)
  - not enough information about screening instruments
  - disapproval from other providers
  - takes too long
  - wouldn't believe patient self-report
  - can't affect patient behavior
  - afraid patient will not return
  - patients will get angry
  - don't want to "label" patient with such problems
4. Would you ask patients about their mood, or how it has changed since the birth of their child?
  5. If you answered yes to the above question, then when would you ask your patients about their mood, or how it has changed since the birth of their child?
  6. After the birth of their child, how often do you ask your patients specifically about their mood, how it may have changed and how they are feeling? Would you say:  
 Rarely  Some of the time  Most of the time  All the time
  7. How often do you advise your patients who may be experiencing a form of depression to get help?  
 Rarely  Some of the time  Most of the time  All the time
  8. How often do you educate or advise patients about PND and how it may impact on their marital relationship, their infant's development and their own emotional wellbeing?  
Would you say:  
 Rarely  Some of the time  Most of the time  All the time
  9. Have you heard of any of the following tools for screening? The EPDC, GHQ, BDI or the Prime-MD? Which ones do you know anything about? What do you know about them?

10. In the past 12 months, how many times did you use a screening tool, such as the EPDC, GHQ, BDI or the Prime-MD, or some other formal screening instrument to assess PND?  
 Rarely  Some of the time  Most of the time  All the time
11. In the past 12 months, if you were concerned about the mood state of the your patient, how many times did you ask her about her emotional wellbeing?  
 Never in the past 12 months  1-2 times  3-5 times  6-11 times  12 or more times
12. What are some reasons why you might or might not screen for PND?

PROBE FOR SOME OF THE FOLLOWING IF NOT MENTIONED:

- no time to screen
- no time to treat if screening identifies problems
- no ability to treat if screening identifies problems
- other priorities are higher (such as? \_\_\_\_\_)
- not enough information about screening instruments
- disapproval from other providers
- takes too long
- wouldn't believe patient self-report
- can't affect patient behavior
- afraid patient will not return
- patients will get angry
- don't want to "label" patient with such problems

Would you give the same reasons if we were talking about screening for a different health behaviour (such as patients who are overweight)? What is the difference between screening for depression, and other health behaviours?

13. If you had enough time, what would you say is the main reason for NOT screening for PND?
14. Who is the optimal health worker in the clinic/practice to conduct screening for PND? Why do you say this?
- a. In terms of time?
  - b. In terms of qualifications?
  - c. In terms of patient preferences?
15. Who is the optimal health worker to refer PND cases to for treatment PND? Why do you say this?
16. How often and in what situations have you referred patients for assessment and/or treatment for PND?
17. What kind of patient would you be most likely to refer? Least likely?
18. Where do you refer patients?

19. Do you feel that you have enough information about public and free PND support groups and programmes in your area to know where to refer patients?
20. If you would like to screen more often for PND, what sort of things may assist you or be useful to you? (For example, trainings, guidelines, protocol, standardized instruments?)
21. If there was research to show formal screening is beneficial, how high a priority would you place on depression related problems? Why do you say this?
22. When is the optimal time to screen for PND?
23. If a PND protocol were to be developed, could you offer any recommendations?

THANK YOU FOR YOUR TIME.

University of Cape Town

# **Information Sheet and Consent Form**

University of Cape Town

## **Consent to participate in a research study:**

Health Practitioner's Attitudes Towards and Experience of Screening for Postnatal Depression

Dear Health Practitioner

### **Study Purpose**

You are being asked to participate in a research study being conducted by myself; a clinical psychology masters students from the University of Cape Town. The purpose of this study is to explore health practitioners' (including general practitioners, gynaecologists, paediatricians and nurses from the vaccination clinic) attitude towards and experience of screening for postnatal depression in female patients.

You are being invited to participate in this study because you provide perinatal or postnatal care to women and/or their infant.

### **Study Procedures**

If you decide to participate in this study, you will be asked to engage in an interview which should take approximately 30 minutes. The interview will address questions relating to your knowledge and opinion of postnatal depression, awareness of screening techniques and issues relating to the assessment of postnatal depression in women. You may be requested to participate in a focus group discussion regarding the above topic, and you may also be requested to administer a screening for post-natal depression to a few of your patients.

All information obtained from you will be kept strictly confidential, and your name will not be associated with the information that appears in my report.

### **Possible Risks**

There are no other known risks specific to this kind of study participation.

### **Possible Benefits**

I hope that my work will increase your awareness around postnatal depression and assist you in the task of identifying and caring for female patients who may be suffering from it. I also hope that information gained from this study will help me answer important questions about postnatal depression and the extent to which it is being identified in health settings.

### **Alternatives**

You may choose not to participate in this study, and this decision will not affect your employment or your relationship with your practice, clinic or hospital in any way.

### **Voluntary Participation**

Participation in this study is completely voluntary. You are free to refuse to answer any question. If you decide to participate, you are free to change your mind and discontinue participation at any time.

### **Confidentiality**

Information about you obtained for this study will be kept confidential. Your name and other identifying information will not be kept with the interview data. It and this consent form will be kept in separate, locked file cabinets, and there will be no link between the consent form and the interview. Only the researcher and her supervisor will have access to this data. The information obtained from the interview will not be made available to anyone else. Any reports or publications about the study will not identify you or any other study participant.

### **Questions**

Any study-related questions, problems or emergencies should be directed to the following researchers:

Jenny Back (researcher) 082 870 6006

Dr. Catherine Ward (supervisor) 021 650 3422

If you have any concerns about the way the study was conducted, or your rights as a participant, please feel free to contact the Department of Psychology at the University of Cape Town on 021 650 3435.

I have read the above and am satisfied with my understanding of the study, its possible benefits, risks and alternatives. My questions about the study have been answered. I hereby voluntarily consent to participation in the research study as described.

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of participant (printed)

\_\_\_\_\_  
Witness

\* \* \*

My interviews may be recorded to assist the interviewer with remembering the information. The only person who will listen to the tape is the interviewer. After s/he has listened to it, it will be destroyed. Information from the interview will be recorded anonymously.

I agree that the conversation may be recorded.

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of participant (printed)

\_\_\_\_\_  
Witness

University of Cape Town